

## Immunohematology Reference Laboratory Requisition Form

<b>Submitting Facility Information</b>			
Facility Name:			
Requesting Physician:			
Name of Person Completing Form:			
Sample Pickup Needed: <input type="checkbox"/> No <input type="checkbox"/> Yes Time of Pickup (if Yes):			
Priority: <input type="checkbox"/> STAT <input type="checkbox"/> ASAP <input type="checkbox"/> Routine <input type="checkbox"/> Specific Date/Time:			
<b>Patient and Sample Information</b>			
Last Name:		First Name:	
Date of Birth: / /		Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	Ethnicity:
Patient ID#:	Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Hgb:	
Sample ID:	Date: / /	Time:	Phleb. ID:
<b>Testing Requested</b>			
<input type="checkbox"/> ABORh <input type="checkbox"/> ABORh Discrepancy <input type="checkbox"/> Antibody ID <input type="checkbox"/> DAT Investigation <input type="checkbox"/> Elution <input type="checkbox"/> Neonatal ABORh <input type="checkbox"/> Neonatal DAT <input type="checkbox"/> Rh (E, e, C, c)/K Phenotype <input type="checkbox"/> Extended Phenotype (Rh, K, Fy, Jk, MNSs) <input type="checkbox"/> Specific Antigens:			
Other Testing (will require send out to another testing facility, CCBC will handle all logistics):			
<input type="checkbox"/> Molecular Antigen Type <input type="checkbox"/> RHCE Genotype <input type="checkbox"/> Weak D/Partial D Analysis <input type="checkbox"/> Fetal Genotype <input type="checkbox"/> Paternal Zygosity <input type="checkbox"/> HLA Antibody Testing			
Notes:			
<b>Products Requested</b>			
Physician order to transfuse? <input type="checkbox"/> No <input type="checkbox"/> Yes Date/Time of Transfusion (if Yes):			
<b>Red Cell Units</b>			
# of Units:	<input type="checkbox"/> CMV Neg <input type="checkbox"/> Irradiated <input type="checkbox"/> Sickle Neg <input type="checkbox"/> Washed <input type="checkbox"/> Hct Range		
Antigen Negative: <input type="checkbox"/> Historic <input type="checkbox"/> Screened <input type="checkbox"/> NA			
<input type="checkbox"/> D <input type="checkbox"/> C <input type="checkbox"/> E <input type="checkbox"/> c <input type="checkbox"/> e <input type="checkbox"/> K <input type="checkbox"/> Fy <sup>a</sup> <input type="checkbox"/> Fy <sup>b</sup> <input type="checkbox"/> Jk <sup>a</sup> <input type="checkbox"/> Jk <sup>b</sup> <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> s <input type="checkbox"/> Other:			
<b>HLA Matched Platelets</b>			
# of Units:	HLA Testing Previously Done: <input type="checkbox"/> Yes <input type="checkbox"/> No (must also order HLA Antibody Testing)		
Notes:			
<b>Hospital Results and Patient History</b>			
ABORh:		Known Antibodies:	
Facility where previous antibodies were identified:			
DAT: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Performed			
Antibody Screen Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Performed			
Methodology Used: <input type="checkbox"/> LISS Tube <input type="checkbox"/> PeG Tube <input type="checkbox"/> Gel <input type="checkbox"/> Solid Phase			
<b>Transfusion History</b>			
Transfused within last 3 months?		<input type="checkbox"/> No <input type="checkbox"/> Yes Date(s) (if Yes):	
Transfused prior to last 3 months?		<input type="checkbox"/> No <input type="checkbox"/> Yes Date(s) (if Yes):	
Any transfusion reactions?		<input type="checkbox"/> No <input type="checkbox"/> Yes Type (if Yes)	
Currently pregnant or within last 3 months?		<input type="checkbox"/> No <input type="checkbox"/> Yes Due Date:	
Rh Immune Globulin given?		<input type="checkbox"/> No <input type="checkbox"/> Yes Date (if Yes):	
Notes:			
Medications:			
Diagnosis:			
Order received date/time: _____ Sample received date/time: _____			

## Immunohematology Reference Laboratory Requisition Form

### Form Instructions

1. Contact the IRL before sending samples.  
Hours of Operation: Monday through Friday 0830-1700. An on-call tech is available outside of these hours for emergent situations.  
After hours, please contact Client Services at (559) 224-8244 | fax: (559) 224-6023
2. Fill out this request form completely. Incomplete forms may delay testing and require further communication.
3. Label all samples with: full patient name, second unique patient identifier number, date collected, and phlebotomist ID.  
*Incorrectly labeled specimens will not be tested.*
4. Update the IRL with any changes in the status of the request.
5. Attach copies of any work done at your facility.

### Sample Requirements

#### Serology Testing (ABORh, Antibody ID, DAT, Elution, Antigen Typing)

1 clot tube, 4 EDTA tubes (minimum 20 mL of EDTA)

#### Molecular Testing

1-2 EDTA tubes (minimum volume 10 mL)

#### HLA Antibody Testing

1 clot tube (10 mL), 1-2 EDTA/ACD tubes (minimum 5 mL of EDTA/ACD)

### Additional Information

- All samples submitted for testing will have an ABORh performed, this is part of CCBC's positive patient identification process.
- All red cell units requested with patient testing being performed by CCBC will have compatibility testing performed to ensure units being sent to your facility will be compatible.

### Approximate Turnaround Time for Preliminary Results

- Stat: Within 8 hours
- ASAP: Within 24 hours
- Routine: Within 3 business (M-F) days
- Specific Date/Time: Results and units (if ordered) will be to your facility by specified date and time

#### Notes:

- All turnaround times are measured from the time the sample is received by the laboratory.
- Complex workups may require additional time to resolve. The laboratory will notify your facility if this is the case.
- Samples sent out for specialized testing will be reported as soon as CCBC receives results from the outside facility.