Clear Fields

LIFESOUTH Community Blood Centers

Request for Immunohematology Services

Sample Requirements: 10 to 15 mL of blood collected in three EDTA purple-top tubes

If a crossmatch is requested: (1) additional 3-mL EDTA sample tube (collected at a different draw time) is required, *if patient blood type unknown*

Referral Information

Contact Name:	Phone:	Fax:
Hospital/Facility:	City/State:	
Date/Time Requested:	Date/Time Needed:	

Urgency: ☐STAT ☐ROUTINE ☐ASAP

Patient Information/History (Complete section or apply addressograph. Include all available information.)

Patient Name: _____ (Last) _____ (First) _____ (Middle Initial)

Sex: ☐M ☐F	Physician:
DOB:	Diagnosis:
Patient ID or MR#:	Medications (attach additional documentation if necessary):
Race:	☐Daratumumab ☐Other:

Sample Information

Samples were collected using an electronic ID system or other validated process? ☐Yes ☐No; (1) additional 3-mL EDTA sample tube (collected at a different draw time) is required.

Lab Values

ABO/Rh (if known):	Current Hgb/Hct:	Current platelet count:
Phlebotomist(s) Printed Name or ID:		
Phlebotomist(s) Signature:		
Collection Date(s)/Time(s):		

Transfusion History

Has patient ever been transfused? ☐No ☐Yes; within last 3 months? ☐No ☐Yes

Products previously transfused (check all that apply): ☐RBC; date: ☐Platelets; date: ☐Plasma; date:

Known RBC/platelet antibodies? ☐No ☐Yes; specify:

Pregnancy History ☐N/A

Number of previous pregnancies:	Currently pregnant? ☐No ☐Yes	Received Rhlg? ☐No ☐Yes; date:

Reason for Submission *(attach copy of hospital blood bank workup)*

☐ABO/Rh Typing Discrepancy	☐Neonatal Evaluation/HDN	☐HLA Class I Typing; WBC Count: _____ ☐Other:
☐Antibody Identification	☐Incompatible Crossmatch	☐Red Cell Genotyping-Patient Common Panel; WBC Count: _____
☐Positive Direct Antiglobulin Test (DAT)	☐Suspected Transfusion Rx	☐ABO Genotyping
☐Elution	☐Platelet Refractory Workup	☐Rh Genotyping

Component Information

Add on request? ☐Yes (same sample from previous day) ☐No

Blood Component **Quantity Needed**

☐Red Blood Cells; _____
AC Type (optional): ☐*Any* ☐*AS-1* ☐*CPDA-1* ☐*Other:* _____

☐Platelets _____ ☐Platelet Crossmatch ☐HLA Matched

☐Other; _____
specify: _____

☐Only accept ABO/Rh identical

Special Request(s)

☐Leukoreduced (CMV safe) ☐Irradiated
☐Sickle Cell Negative ☐CMV Seronegative
☐Pediatric Units/Aliquots ☐Washed
☐Other: _____

Crossmatch Requested? ☐No ☐Yes; *if yes, it is recommended that samples for platelet crossmatch be tested 24 hours after collection or less.*

☐Check here to request to extend the sample's age for platelet crossmatch for up to 48 hrs from collection.

Has the patient been previously typed for ABO/Rh (using a sample separate from the one being submitted?) ☐Yes ☐No

- If yes: ABO/Rh Result: _____ Date performed: _____ Tech: _____
- If no: An additional 3-mL EDTA sample (drawn at a separate collection time) must be submitted.

For IRL Laboratory Use Only

Testing performed by: ☐GA-IRL ☐FL-IRL
Comments:

Accession Number:

☐SAU Hx ☐SAU Conf ☐Fresh ☐Vol indicated ☐HbS-
☐Leukoreduced ☐Irradiated ☐CMV- ☐# Units filled

Pending # Units: _____ Reviewed/Verified by: _____

Time sample received in IRL: _____

FL-IRL: FAX COMPLETED FORM TO (352) 334-1029 • CONFIRM FAX RECEIVED AT (352) 334-1028
Atlanta Area: FAX COMPLETED FORM TO (888) 316-2381 • CONFIRM FAX RECEIVED AT (844) 329-0601