

Sample Requirements: 3 mL of blood collected in one EDTA purple-top tube appropriately labeled with two unique patient identifiers. For DNA testing, WBC must be $\geq 1.0 \times 10^3/\mu\text{L}$; if low WBC (1 to $3 \times 10^3/\mu\text{L}$), provide an additional 10 to 15 mL of blood collected in three EDTA purple-top tubes appropriately labeled with two unique patient identifiers.

Referral Information

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

Urgency: STAT ROUTINE

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

Patient Name: _____		
Last	First	Middle Initial
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Physician:	
DOB:	Diagnosis:	
Patient ID or MR#:	Medications (attach additional documentation if necessary):	
Race:	<input type="checkbox"/> Daratumumab <input type="checkbox"/> Other:	

Lab Values

ABO/Rh (if known):	Current WBC: $\times 10^3/\mu\text{L}$	Current platelet count: $\times 10^3/\mu\text{L}$
Phlebotomist(s) Printed Name or ID:		
Collection Date(s)/Time(s):		

Transfusion History

Has patient ever been transfused? <input type="checkbox"/> No <input type="checkbox"/> Yes; within last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes
Products previously transfused (check all that apply): <input type="checkbox"/> RBC; date: <input type="checkbox"/> Platelets; date: <input type="checkbox"/> Plasma; date:
Known RBC/platelet antibodies? <input type="checkbox"/> No <input type="checkbox"/> Yes; specify:
History of transplant? <input type="checkbox"/> Solid Organ <input type="checkbox"/> Stem Cell/ Bone Marrow <input type="checkbox"/> No

Pregnancy History N/A

Number of previous pregnancies:	Currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	Received Rhlg? <input type="checkbox"/> No <input type="checkbox"/> Yes; date:
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Reason for Submission (Attach copy of hospital blood bank workup.)

<input type="checkbox"/> Platelet Refractory Workup	<input type="checkbox"/> Red Cell Genotyping-Patient Common Panel	<input type="checkbox"/> Other:
<input type="checkbox"/> HLA Class I Typing	<input type="checkbox"/> ABO Genotyping*	
<input type="checkbox"/> HLA antibody screen and ID if positive	<input type="checkbox"/> Rh Genotyping*	
<input type="checkbox"/> Platelet Antibody Assay	<input type="checkbox"/> Hemoglobinopathy Testing (Capillary Electrophoresis)	

*Serology Results (If requesting ABO or Rh genotyping, include copy of results and reason for requesting testing.)

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For Special Testing Laboratory Use Only

Accession Number:	Comments:
Date/Time sample received in lab:	

Send the completed form along with shipping tracking/expected time of sample drop off (if local) to qc@lifesouth.org.