Telephone: (937) 461-3264	**After Hours:** (937) 461-7557 Ask for Reference Laboratory On-Call Technologist	**Fax:** (937) 461-2738

***INSTRUCTIONS*:**

1. **Please call the Reference Laboratory before sending samples, regardless if the request is urgent or routine (not time sensitive). This allows for the tracking and prioritizing of samples received in the Reference Laboratory.**
2. Complete the first page of this form as completely as possible concerning the hospital and patient information. A medication history is not critical unless anemia is unexplained and may be due to drug administration. Race and diagnosis are very important pieces of information that often give the Reference Laboratory direction for the resolution of the problem. A date of birth or social security number MUST be provided in order to process any sample.
3. Complete the second page of this form to indicate the problems that have been observed by your facility and what tests are being requested. Also record the date that the sample was collected and all relevant hospital laboratory findings.
4. Our Reference Laboratory does not perform red cell crossmatching as part of the case resolution. However, a space exists at the bottom of page 2 to record the number of red cell products needed for the patient if clinically significant antibodies are identified. It also has a section to mark any special requests for the product such as leukoreduction, irradiation, or "other".
5. See page 3 of this form for **specimen and shipping requirements** for various kinds of cases that are referred for testing.

Hospital	***Telephone Number for Report***

Patient Name	***Age***	***Race***	***Sex***

Diagnosis	***Physician***	***D.O.B. or Social Security Number***

Medications: (please provide if requested by Reference Lab Staff)	***Medical Record Number (optional)***

Number of Pregnancies:_____ ***Pregnant now? _____*** ***Date Due:_____***

Does the patient have a history of red cell or platelet transfusion: (REQUIRED INFORMATION)

Within Last 4 Months: ☐ ***Yes*** ☐ ***No*** ***If So, Dates:_____***

Prior to Last 4 Months ☐ ***Yes*** ☐ ***No*** ***If So, Dates:_____***

Previous Transfusion Reaction: ☐ ***Febrile*** ☐ ***Allergic*** ☐ ***Hemolytic*** ☐ ***Other (describe)***

Hemoglobin/Hematocrit: ***Retic***: ***Bilirubin***: ***Platelet Count:***

Has patient previously been referred to this lab or to any other consultation lab?	☐ **Yes**	☐ **No**

If yes, where?	***When?***

Results:

(Also complete information on the reverse side of this form – page 2)

Nature of Difficulty (Please mark all that apply):

- ☐ ABO Typing Problem
- ☐ Rh(D) Typing Problem
- ☐ Incompatible Crossmatch
- ☐ Suspected Transfusion Reaction
- ☐ Other_____
- ☐ Hemolytic Disease of Fetus and Newborn (HDFN)
- ☐ Unidentified Antibodies
- ☐ Positive Direct Antiglobin Test (DAT)
- ☐ Platelet Refractoriness

Requested Tests

- ☐ Reference Case (includes antibody identification and all tests deemed necessary by the reference laboratory for complete resolution of the problem, i.e., adsorptions, elutions, associated ABO and Rh(D) typing problems, etc.)
- ☐ Resolution of ABO Type and/or Rh(D) Type
- ☐ Platelet Crossmatch (Please check with CBC before ordering.)
- ☐ Molecular RBC genotyping
- ☐ Other (please specify):

Hospital Laboratory Findings: (Please submit copies of panel sheets and/or screening results)

Date Sample Collected:_____

ABO Group_____ Rh(D) Type_____ Other Phenotyping:_____

DAT Testing: Polyspecific_____ anti-IgG_____ anti-complement:_____

Antibodies identified (including those previously identified):_____

Antibodies suspected:_____

Enhancement Used (mark all that apply):

☐ LISS | ☐ PEG | ☐ Gel | ☐ Saline | ☐ Enzyme | ☐ Solid Phase | ☐ Other_____

Transfusion Requirements:

Number of Red Cell Products Needed (**will not** be crossmatched by Ref Lab):_____

Special Requests (mark all that apply):

☐ Leuko-reduced ☐ Irradiated ☐ Other_____

Comments:

Sample Requirements:

1. Routine antibody identification (suspected single or multiple alloantibodies):
   Minimum of 5 ml of EDTA anticoagulated blood and 7 ml of clotted blood (plain red top tube – NO serum separator tubes)
2. Suspected warm autoantibody:
   Minimum of 10 ml (2 tubes) of EDTA anticoagulated blood and 7 ml of clotted blood (plain red top tube – NO serum separator tubes)
3. Investigation of suspected hemolytic transfusion reaction:
   a. P**re**-transfusion sample (including EDTA tube if possible)
   b. P**ost**-transfusion samples (minimum of 1 EDTA tube and 1 blood bank clot tube)
   c. Unit number(s) of suspected unit(s) and segments from units if possible
4. Investigation of suspected HDFN (Hemolytic Disease of the Fetus/Newborn):
   a. Mother: 1 EDTA tube and 1 clot tube
   b. Baby: minimum of 2 cc of anticoagulated whole blood
   c. Biologic Father (only if antibody to a low incidence antigen is suspected): 1 EDTA tube
5. Platelet Antibody Investigations (includes platelet crossmatching and additional testing as needed):
   Minimum of 5 ml of EDTA anticoagulated blood and 7 ml of clotted blood (plain red top tube – NO serum separator tubes).
   NOTE: if the patients WBC count is 1,000 or below, a minimum of 10 ml of EDTA anticoagulated blood will be required.
6. Molecular RBC genotyping:
   Minimum of 5 ml of EDTA anticoagulated blood. **NOTE:** If the patients WBC count is 1,000 or below, a minimum of 10 ml of EDTA anticoagulated blood will be required. Also see Indications for Molecular RBC genotyping below.
7. Thermal Amplitude testing or Donath-Landsteiner test:
   Call the Reference Laboratory for specific directions for sample collection and shipping.

Shipping Requirements:

Any samples shipped to the Reference Laboratory must be sufficiently packaged to prevent leakage and breakage during transport. Regulations for the shipment of biologic materials must be followed. Samples may be shipped at room temperature or on wet ice. A request form must accompany all samples.

Tube Labeling Requirements:

1. Patient's blood samples must be sent in stoppered tubes with firmly attached labels containing the patient's first and last names, social security number and/or birth date, and the date the tubes were drawn. The patient's first and last names must match what is recorded on this form. The Reference Laboratory reserves the right to reject specimens that are not properly labeled or collected according to the above sample requirements.
2. If sending samples after hours, please separate the serum/plasma from the red cells into clearly labeled tubes before sending.

Indications for Molecular RBC genotyping:

Molecular RBC genotyping is recommended for any patient for whom a serologic phenotype is difficult to obtain; it is also recommended for selected patients with complex serologic problems. This would include patients who have positive DATs (with or without an underlying warm autoantibody), patients who have been recently transfused, selected patients with multiple alloantibodies, and patients with an antibody to a high prevalence antigen. Molecular RBC genotyping is also recommended for sickle cell anemia and thalassemia patients. The Reference Laboratory reserves the right to obtain additional information for orders for molecular RBC genotyping that are not consistent with these recommendations.