Transfusion Service Consultation Request

Specimen Requirements: Submit two 7 ml EDTA tubes (or three 4 ml EDTA tubes)

Samples MUST be labeled with ALL of the following:

- Patient First and Last name
- Patient ID # (i.e. Date of Birth, Hospital # or SSN)
- Date and Time collected

NOTE: IMPROPERLY LABELED SAMPLES WILL NOT BE TESTED

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Submitting Facility Information:

Facility Name and City:_____ Request Date:_____
Contact Person:_____ Contact Phone Number:_____
Requesting Physician: _____

Patient Information:

Patient Name: _____ Birth Date/Age:_____
Patient SSN or Hospital ID:_____ Gender M___ F____
Specimen Date:_____ Patient ABO/Rh Type_____ Hgb/Hct:_____
Diagnosis:_____
Additional Information:_____

Transfusion History: No record____
Within last 3 months: No___ Yes___ Dates/products: _____
Prior to last 3 months: No___ Yes___ Dates/products: _____

Previously identified Antibodies:_____

Pregnancy History: Number:_____ Currently Pregnant? No___ Yes___

Has patient received Rhogam in the last 6 months? No___ Yes___

Note: It is standard policy at GPRMC to do a D negative antibody screen on patients who have received Rhogam in the last 6 months. This will detect other significant antibodies in a specimen know to contain anti-D (from Rhogam injection).

Submitting Facility's Antibody Testing results:

Tube___		IS	37C	AHG (Gel)	Crossmatches:
Gel____	I	_____	_____	_____	# Compatible_____
Other___	II	_____	_____	_____	DAT_____
	III	_____	_____	_____	# Incompatible_____

Tests Requested:

_____Antibody Identification
_____Antigen Screening on Unit Segments For Appropriate Antibodies
(Segments sent from _____ units)
_____D negative antibody screen on Patient who has received Rhogam in the last 6 months
_____Other (Please Specify)_____