San Diego Blood Bank

2800019.v5.FRM

Immunohematology Consultation Request

California Clinical Lab ID# CLF1236
CLIA No. 05D643088
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San Diego, CA 92102
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INSTRUCTIONS:

1. Please call the IRL before sending specimens.
2. Submit 10-20cc of clotted blood and 10-20cc of anticoagulated blood.
   For recently transfused patients, submit pretransfusion red cells if available.
3. Send blood in stoppered tubes that prevent leakage. Do not use tubes with serum separators.
4. Label each tube with patient's first and last names, DOB or MR#, date and time of collection.
5. Complete each item on this form.
6. Mark the container "ATTN: IRL".

Improperly Labeled Tubes Will Not Be Tested

PATIENT INFORMATION

Patient Name: _____ DOB: _____ MR#: _____

Sex: _____ Ethnicity: _____ Hemoglobin / Hematocrit: _____Date Specimen Collected: _____

Clinical Diagnosis: _____Ordering Physician (required): _____

Medications: _____

Transfusion History: Within last 3 months, dates: _____

Prior to last 3 months, dates: _____

No. of Pregnancies: _____Pregnant Now? _____Due Date: _____History of HDN? _____

Has the patient received Rh Immune Globulin? _____ Date of injection: _____

Known RBC antibody(ies): Anti-D ☐ -C ☐ -E ☐ -c ☐ -e ☐ -K ☐ -S ☐ -s ☐ -Fy^a ☐ -Fy^b ☐ -Jk^a ☐ -Jk^b ☐

Other (list): _____

TEST(S) / INVESTIGATION REQUESTED

☐ ABO-Rh typing
☐ Antibody Identification
☐ Transfusion Reaction
☐ Direct Antiglobulin Test
☐ Hemolytic Disease of the Fetus and Newborn
☐ Platelet Crossmatch
☐ Red Cell Antigen Genotype (Molecular)*
☐ Other_____

*Red Cell Antigen Genotype (Molecular) is recommended if a warm autoantibody is identified or patient has been transfused.

Urgency:		**Products Requested:** Quantity_____ Date & time needed:_____	
☐ Routine (24-48 hours)	☐ Stat (8 hours)	☐ CMV Negative	☐ Hemoglobin S Negative
☐ ASAP (24 hours)	**Stat Fees Will Apply**	☐ Irradiated	☐ Other_____

RESULTS OF YOUR STUDIES (Attach Copies)

ABO-Rh Groups: _____ Direct Antiglobulin Test: _____

Test Method: ☐ LISS ☐ PEG ☐ GEL ☐ OTHER please list _____

REQUESTING HOSPITAL:	**PHONE & FAX REPORT TO :**