



California Clinical Lab ID# CDF1236
 CLIA No. 05D643088
 Mark Edmunds, MD, Chief Medical Officer

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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

- | | | |
|---|---|---|
| <input type="checkbox"/> ABO-Rh typing | <input type="checkbox"/> Antibody Identification | <input type="checkbox"/> Transfusion Reaction |
| <input type="checkbox"/> Direct Antiglobulin Test | <input type="checkbox"/> Hemolytic Disease of the Fetus and Newborn | |
| <input type="checkbox"/> Platelet Crossmatch | <input type="checkbox"/> Red Cell Antigen Genotype (Molecular)* | |
| <input type="checkbox"/> Other | | |

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

Urgency: <input type="checkbox"/> Routine (24-48 hours) <input type="checkbox"/> Stat (8 hours) <input type="checkbox"/> ASAP (24 hours) Stat Fees Will Apply		Products Requested: Quantity _____ Date & time needed: _____ <input type="checkbox"/> CMV Negative <input type="checkbox"/> Hemoglobin S Negative <input type="checkbox"/> Irradiated <input type="checkbox"/> Other _____	
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RESULTS OF YOUR STUDIES (Attach Copies)

ABO-Rh Groups: _____ Direct Antiglobulin Test: _____

Test Method: LISS PEG GEL OTHER please list _____

<p align="center">REQUESTING HOSPITAL:</p>	<p align="center">PHONE & FAX REPORT TO :</p>
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