

**REQUEST FOR IMMUNOHEMATOLOGY REFERENCE LABORATORY TESTING**

**Workup Urgency:**    Routine       ASAP       Life-threatening

<b>I. SPECIMEN INFORMATION</b>			
Patient's Name (Last, First)	Date of Birth	Medical Record Number	Ethnicity
Date Sample Drawn: _____ Date Sample Sent: _____			
Pre-Transfusion Sample Available: Y/N      If Yes, Draw Date: _____			
<b>II. PATIENT INFORMATION</b>			
Hgb/Hct: _____      Active Bleeding: Y / N      Signs of Hemolysis: Y / N      HDN: Y / N Admitting Diagnosis: _____ Medications: _____			
<u>Transfusion History</u> <ul style="list-style-type: none"> <li>• Within past 3 months      # Units: _____      Date: _____</li> <li>• Prior transfusions      # Units: _____      Date: _____</li> <li>• Transfusion Reaction History      Y / N      Date: _____</li> </ul>			
<u>Pregnancy History</u> <ul style="list-style-type: none"> <li>• Is patient pregnant now: Y / N      If yes, # of weeks: _____      Delivered in last 3 months: Y / N</li> <li>• Number of Pregnancies: _____      History of HDN: Y / N</li> <li>• Has patient received (circle one) Rh Immune globulin,      IVIG,      Stem cell transplant: Y / N                Date given: _____</li> </ul>			
<b>III. HOSPITAL TESTING INFORMATION</b>			
ABO/D: _____      DAT: Poly: _____      -IgG: _____      -C3: _____      Control: _____ Known antibodies: _____ Previously tested by CBS IRL: Y / N      Reference #: _____ Describe current transfusion problem and/or reason for sample submission: _____ _____ <p style="text-align: center;">**Please attach copies of testing whenever possible**</p>			
<b>IV. CONTACT INFORMATION</b>			
Contact Person: _____      Phone: (_____) _____ FAX: _____      E-mail: _____ Ordering Physician: _____ Hospital: _____ Address: _____ City: _____      State: _____      Zip Code: _____			

*For CBS Staff Use: Date/Time Sample Received: \_\_\_\_\_ By: \_\_\_\_\_*

**SEE REVERSE SIDE OF FORM**

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**V. IMMUNOHEMATOLOGY REFERENCE LABORATORY**

- Laboratory hours are Monday through Friday 7:00 AM to 5:00 PM. Immunohematologists are available ON CALL evenings, weekends, and holidays for emergency requests. (*Emergency work-ups may require approval from our Medical Director.*) An emergency fee will be charged for any work-up requiring completion OFF-HOURS. Please note additional **hourly** surcharge fees apply for testing performed or completed **after** midnight.
- Please notify the Immunohematology Reference Laboratory **BEFORE** sending patient specimens.
- CBS IRL:
  - Phone # 201-251-3975
  - FAX # 201-670-6174
  - Manager – Phone # 201-389-0421
  - For emergency requests, OFF-HOURS, contact: Phone # 201-251-3735\*  
\*CBS Hospital Services will contact the on-call immunohematologist.

**VI. SAMPLE REQUIREMENTS**

Patient	Sample Minimum Requirements
Not Recently Transfused	10 mL clotted and 7 mL anticoagulated
Recently Transfused	10 mL clotted and 15 mL anticoagulated
Hemolytic cold reacting antibodies	10 mL clotted and kept at 37C until serum separated; separate serum and clot before submission and ship separated; and 7 mL anticoagulated

**NOTE: IF THE SUBMITTED SAMPLE QUANTITY/VOLUME IS NOT SUFFICIENT (QNS), WE MAY NOT BE ABLE TO PERFORM THE ANTIBODY INVESTIGATION.**

- Send freshly drawn specimens labeled with patient’s name, patient identifier (date of birth or medical record number), date drawn, and phlebotomist’s identity.
- In case of a transfusion reaction investigation, include a segment from the unit with patient’s pre and post-transfusion samples.

**VII. FOR CBS USE ONLY: SAMPLE INTEGRITY/COMMENTS**

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**INSTRUCTIONS FOR COMPLETING THE**

**REQUEST FOR IMMUNOHEMATOLOGY REFERENCE LABORATORY TESTING**

<b>I. Specimen Information</b>	
Patient's Name:	Document patient's name.
Date of Birth:	Document patient's date of birth.
Medical Record Number:	Document medical record number.
Ethnicity:	Document patient's ethnicity.
Date Sample Drawn:	Document date sample was drawn.
Date of Sample Sent:	Document date sample was sent.
Pre-Transfusion Sample Available: Y / N	Yes or No
If Yes, Draw Date:	If answer was yes on the previous question, document draw date.
<b>II. Patient Information</b>	
Hgb/Hct:	Document most recent hemoglobin/hematocrit results.
Active Bleeding:	Yes or No
Signs of Hemolysis: Y / N	Yes or No
HDN: Y/N	Yes or No
Admitting Diagnosis:	Document patient's diagnosis, if known.
Medications:	Document medications the patient is currently taking.
Transfusion History:	
Within past 3 months # Units:	Document the number of units transfused in the past 3 months and the date the units were transfused, if applicable.
Prior transfusions #Units:	Document the number of units transfused prior to the past 3 months and the date transfusion occurred.
Transfusion Reaction History:	Choose Y if the patient has experienced a transfusion reaction in the past or N if the patient has never had a transfusion reaction, if applicable.
Pregnancy History:	
Is patient pregnant now: Y / N	Yes or No
If yes, # of weeks:	Indicate the number of weeks of patient's pregnancy.
Delivered in last 3 months: Y / N	Yes or No
Number of pregnancies:	Document number of pregnancies.
History of HDN: Y / N	Yes or No
Has patient received Rh Immune Globulin, IVIG, Stem cell transplant: Y / N	Circle appropriate answer.
Date given:	Document date given.

**INSTRUCTIONS FOR COMPLETING THE**

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<b>III. Hospital Testing Information</b>	
ABO/D:	Document patient's blood type.
DAT: Poly: _____ IgG: _____ -C3b, -C3d: _____ Control: _____	Document results obtained by hospital or individual tests. (NT if not tested.)
Known antibodies:	Document known antibodies.
Previously tested by CBS IRL: Y / N	Yes or No
Reference #:	Document Reference # from previous work-up.
Describe current transfusion problem and/or reason for sample submission:	Document reason for sample submission.
<b>V. Contact Information</b>	
Contact Person:	Document name.
Phone: FAX: E-mail:	Document phone, FAX and e-mail.
Ordering Physician:	Document physician's name.
Hospital:	Document name of hospital.
City: State: Zip Code:	Document hospital's city, state, and zip code.
<i>For CBS Staff Use:</i> Date/Time Sample Received: _____ By: _____	Document the date/time sample was received and tech name.
<b>VII. FOR CBS USE ONLY: SAMPLE INTEGRITY/COMMENTS</b>	Document sample integrity or any other comment(s) that may be related to the sample or request.