IMMUNOHEMATOLOGY CONSULTATION REQUEST

THE BLOOD CENTER
Serving you for life!

☐ **New Orleans Lab**
2609 Canal Street
New Orleans, LA 70119
(504) 592-1569
(504) 592-1570 fax

☐ **Hammond Lab**
1213 Suite A. West Morris Ave.
Hammond, LA 70403
(985) 345-4092
(985) 902-7918 fax

SAMPLE SUBMISSION INSTRUCTIONS

1. All requests must be phoned to the Reference Lab before sending samples.
2. Fill out this request form as **completely** and **accurately** as possible.
3. Minimum sample requirements: 2 tubes of clotted blood and 2 tubes of EDTA anticoagulated blood.
   All samples must be labeled with the patient's name, facility ID number, date of collection and collector's initials.
   INCOMPLETE OR MISLABELED SPECIMENS WILL NOT BE ACCEPTED!
4. Attach copies of current serological testing (if available) with this form to send with samples.
5. Send samples/paperwork by courier or call Hospital Services (800-86-BLOOD or 985-340-2343) to request a sample pickup.
6. Preliminary reports will be called/faxed ASAP. Final reports will be mailed after TBC Medical Director review.

SUBMITTING HOSPITAL / FACILITY ____________________

TELEPHONE NUMBER____________________ FAX NUMBER ____________________

SPECIMEN COLLECTED - DATE __________ TIME __________ DATE SPECIMEN SENT ____________________

PATIENT INFORMATION

NAME ____________________ GENDER ☐ M ☐ F RACE ____________________

HOSPITAL/FACILITY ID # ____________________ DIAGNOSIS ____________________

SOCIAL SECURITY # ____________________ CURRENT MEDICATIONS ____________________

DATE OF BIRTH ____________________ ____________________

CLINICAL HISTORY

PREVIOUSLY IDENTIFIED ANTIBODIES ____________________

METHOD USED: ☐ GEL ☐ SOLID PHASE ☐ TUBE ENHANCEMENT USED: ☐ LISS ☐ PEG ☐ ALBUMIN ☐ NONE

PREVIOUSLY TRANSFUSED? ☐ Y ☐ N DATES:____________________ QUANTITY ________ ABORh __________

OF PREVIOUS PREGNANCIES (INCLUDING MISCARRIAGES/ABORTIONS) __________ HISTORY OF HDN? ☐ Y ☐ N

EXPECTED DELIVERY DATE ______________ RECEIVED RhIG? ☐ Y ☐ N DATES: ______________

REQUESTED TESTING (CHECK ALL THAT APPLY)

☐	ABO TYPING DISCREPANCY	☐	DAT / ELUTION STUDIES
☐	Rh TYPING DISCREPANCY	☐	SEROLOGICAL PATIENT PHENOTYPE
☐	ANTIBODY IDENTIFICATION	☐	MOLECULAR PATIENT PHENOTYPE
☐	ANTIBODY CONFIRMATION OF __________	☐	PATIENT PHENOTYPE OF __________
☐	ANTIBODY TITRATION OF __________	☐	HDN WORKUP
☐	PLATELET ANTIBODY SCREEN	☐	TRANSFUSION REACTION WORKUP
☐	PLATELET CROSSMATCH	☐	OTHER __________

REQUESTED BLOOD PRODUCTS (CHECK ALL THAT APPLY)

NUMBER OF UNITS __________		**TESTING/UNITS NEEDED:**
	☐ LEUKOREDUCED	
☐ RED BLOOD CELLS	☐ IRRADIATED	☐ STAT (WITHIN 8 HOURS)
☐ PLATELETS, CROSSMATCHED	☐ CMV-NEGATIVE	☐ ASAP (1-2 BUSINESS DAYS)
☐ OTHER __________	☐ SICKLE CELL-NEGATIVE	☐ ROUTINE
	☐ WASHED	☐ FOR SURGERY, DATE ________