

IMMUNOHEMATOLOGY CONSULTATION REQUEST



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

TESTING/UNITS NEEDED:

	STAT (WITHIN 8 HOURS)
	ASAP (1-2 BUSINESS DAYS)
	ROUTINE
	FOR SURGERY, DATE _____

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 MISLABLED 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)

<input type="checkbox"/> ABO TYPING DISCREPANCY <input type="checkbox"/> Rh TYPING DISCREPANCY <input type="checkbox"/> ANTIBODY IDENTIFICATION <input type="checkbox"/> ANTIBODY CONFIRMATION OF _____ <input type="checkbox"/> ANTIBODY TITRATION OF _____ <input type="checkbox"/> PLATELET ANTIBODY SCREEN <input type="checkbox"/> PLATELET CROSMATCH	<input type="checkbox"/> DAT / ELUTION STUDIES <input type="checkbox"/> SEROLOGICAL PATIENT PHENOTYPE <input type="checkbox"/> MOLECULAR PATIENT PHENOTYPE <input type="checkbox"/> PATIENT PHENOTYPE OF _____ <input type="checkbox"/> HDN WORKUP <input type="checkbox"/> TRANSFUSION REACTION WORKUP <input type="checkbox"/> OTHER _____
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REQUESTED BLOOD PRODUCTS (CHECK ALL THAT APPLY)

<input type="checkbox"/> NUMBER OF UNITS _____ <input type="checkbox"/> RED BLOOD CELLS <input type="checkbox"/> PLATELETS, CROSMATCHED <input type="checkbox"/> OTHER _____	<input type="checkbox"/> LEUKOREDUCED <input type="checkbox"/> IRRADIATED <input type="checkbox"/> WASHED	<input type="checkbox"/> CMV-NEGATIVE <input type="checkbox"/> SICKLE CELL-NEGATIVE
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