

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

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 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)

<input type="checkbox"/> ABO TYPING DISCREPANCY	<input type="checkbox"/> DAT / ELUTION STUDIES
<input type="checkbox"/> Rh TYPING DISCREPANCY	<input type="checkbox"/> SEROLOGICAL PATIENT PHENOTYPE
<input type="checkbox"/> ANTIBODY IDENTIFICATION	<input type="checkbox"/> MOLECULAR PATIENT PHENOTYPE
<input type="checkbox"/> ANTIBODY CONFIRMATION OF _____	<input type="checkbox"/> PATIENT PHENOTYPE OF _____
<input type="checkbox"/> ANTIBODY TITRATION OF _____	<input type="checkbox"/> HDN WORKUP
<input type="checkbox"/> PLATELET ANTIBODY SCREEN	<input type="checkbox"/> TRANSFUSION REACTION WORKUP
<input type="checkbox"/> PLATELET CROSSMATCH	<input type="checkbox"/> OTHER _____

REQUESTED BLOOD PRODUCTS (CHECK ALL THAT APPLY)

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