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 _____

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