



Springfield: Phone 217-753-9443 Fax 217-528-3271	Davenport: Phone 563-823-8933 Fax 563-441-1904
St. Louis: Phone 314-291-4752 Fax 314-291-4746	Madison: Phone 608-590-4073 Fax 608-292-1690

Instructions: All submitted samples (including secondary tubes) MUST be labeled with the patient's full name and a unique identifier (hospital ID, BBID, DOB). The date / time of collection and identity of the phlebotomist may be labeled either on the specimen or on the request form. Improperly labeled specimens will NOT be processed.

Sample Requirements: SEE PAGE 2

Date Called: _____ **Time Called:** _____ **Person Contacted:** _____

STAT (patient critical; active bleeding) ASAP Routine Specific Date / Time: _____

Hospital Information

Hospital Name:	Phone:	Ext:
Form Completed By:	Fax:	

Patient Information (Please attach medication list.)

Patient Name (Last Name, First Name):		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Patient Hospital / Med Rec #:	Patient DOB:	
Ethnicity:	Diagnosis:	Ordering Provider:
ABO / RH:	Previous or Known Antibodies:	
Transfused in the LAST 3 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of LAST Transfusion:	
EVER received RhIG? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of Last RhIG Administration:	
Date / Time Sample Collected:		Collected By:
Are there current orders to transfuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Status: <input type="checkbox"/> In Patient <input type="checkbox"/> Out Patient <input type="checkbox"/> Labor/Delivery <input type="checkbox"/> Trauma <input type="checkbox"/> Emergency Surgery <input type="checkbox"/> Elective Surgery	

Hospital Test Results (Please submit a copy of results obtained at your facility.)

H/H:	Please briefly describe obtained results:
Antibody Reactivity: <input type="checkbox"/> Gel <input type="checkbox"/> Solid Phase <input type="checkbox"/> Tube	Potentiator: <input type="checkbox"/> PeG <input type="checkbox"/> LISS <input type="checkbox"/> Other: _____

Type of Service Requested

<input type="checkbox"/> Full Antibody ID	<input type="checkbox"/> Eluate*	<input type="checkbox"/> HDN - Baby Workup	<input type="checkbox"/> HDN - Mother Workup
<input type="checkbox"/> Routine Prenatal*	<input type="checkbox"/> Direct Antiglobulin Test*	<input type="checkbox"/> Antigen Type*: _____	
<input type="checkbox"/> ABO Discrepancy Resolution*	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> HLA / HPA PLT Antibody Investigation	Molecular Request:	<input type="checkbox"/> RBC Molecular Phenotype	<input type="checkbox"/> RHD Variant
		<input type="checkbox"/> RHCE Variant	<input type="checkbox"/> HLA Molecular Phenotype
		<input type="checkbox"/> HPA Molecular Phenotype	

* Abbreviated Workup

Unit(s) Requested (Red Blood Cells)

<input type="checkbox"/> ABO Compatible Acceptable	<input type="checkbox"/> Antigen Confirmed	Date / Time Product Needed By:
<input type="checkbox"/> ABO Identical is Required	<input type="checkbox"/> Historical	
Special Requirements: <input type="checkbox"/> CMV Negative <input type="checkbox"/> Hgb S Negative <input type="checkbox"/> Irradiated <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Antigen negative for: _____		

Unit(s) Requested (Platelets)

<input type="checkbox"/> First / Best Available PLT Product	<input type="checkbox"/> Crossmatched PLT Product	<input type="checkbox"/> HLA / HPA Matched PLT Product
Special Requirements: <input type="checkbox"/> CMV Negative <input type="checkbox"/> Irradiated <input type="checkbox"/> Other: _____		

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Sample Requirements: NO GEL SEPARATOR TUBES (IMPROPERLY LABELED SPECIMENS WILL NOT BE PROCESSED)	
FULL Red Cell Antibody Investigation:	4 EDTA tubes - 7mLs
ROUTINE Prenatal Workup (Abbreviated):	2 EDTA tubes - 7mLs
ABO Discrepancy Resolution (Abbreviated):	4 EDTA tubes - 7mLs
Antigen Type (Abbreviated):	1 EDTA tube - 7mLs
Direct Antiglobulin Test (Abbreviated):	1 EDTA tube - 7mLs
Eluate (Abbreviated):	2 EDTA tubes - 7mLs
HDN - Baby Workup:	Cord blood sample OR ≥ 3 EDTA microtainers
HDN - Mother Workup:	2 EDTA tubes - 5mLs
Molecular Requests:	1 EDTA tube - 2mls or 2 buccal swabs
HLA / HPA Platelet Antibody Investigation:	2 Serum tubes - 7mls (NO SST Tubes) & 2 EDTA tubes - 7mls

ImpactLife Use Only:		NA <input type="checkbox"/>
BloodHub Entry Completed		
Initials:	Date/Time:	BloodHub#: