MISSISSIPPI VALLEY REGIONAL BLOOD CENTER

Z-001: Reference Laboratory Consultation Request

Springfield:	Phone 217-753-9443	Fax 217-528-3271	Davenport:	Phone 563-823-4145	Fax 563-441-1904
St. Louis:	Phone 314-291-4752	Fax 314-291-4746	Urbana:	Phone 217-369-2699	Fax 217-367-9440 (RBC's ONLY)
Madison:	Phone 608-590-4073	Fax 608-590-4076			

Instructions: All submitted samples (including secondary tubes) MUST be labeled with the patient's full name, unique identifier (hospital ID, BBID, DOB). The date/time of collection and identity of the phlebotomist can be either on the specimen or on the request form.

Sample Requirements: NO GEL SEPARATOR TUBES (IMPROPERLY LABELED SPECIMENS WILL NOT BE PROCESSED)	
FULL Red Cell Antibody Investigation: 4 EDTA tubes - 7mLs	Eluate ONLY Workup: 2 EDTA Tubes - 7mLs
Labor / Delivery: 2 EDTA tubes - 7mLs	HDN Investigations:
ABO Discrepancy Requests: 4 EDTA tubes - 7mLs	Mother - 2 EDTA tubes - 5mLs
Antigen Type / DAT Requests ONLY: 1 EDTA tube – 7mLs	Baby - Cord blood sample OR 3 EDTA microtainers

Date Called: _____ **Time Called:** _____ **Contact Person:** _____

☐ 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)		☐ Male ☐ Female ☐ Unknown
Patient Hospital / Med Rec #:	Patient DOB:	
Race:	Diagnosis:	Physician:
ABO/RH:	Previous Antibodies:	
Transfused in the LAST 3 Months? ☐ Yes ☐ No ☐ Unknown		Date of LAST Transfusion:
EVER received RhIG? ☐ Yes ☐ No ☐ Unknown		Date of Last RhIG Administration:
Date / Time Sample Collected:		Collected By:

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

H/H:	DAT:	AHG Crossmatches: ☐ Not Tested ☐ Neg ☐ Pos
Antibody Reactivity: ☐ Gel ☐ Solid Phase ☐ Tube		Potentiator: ☐ PeG ☐ LISS ☐ Other: _____

Type of Service Requested

☐ Full Antiobdy ID ☐ Abbrev – Labor/Delivery ☐ HDN – Baby Workup ☐ HDN - Mother Workup
☐ ABO Discrepancy ☐ RH Discrepancy ☐ DAT ONLY ☐ DAT with Eluate
☐ Eluate Workup ONLY ☐ Routine Prenatal ☐ Antigen Type: _____
☐ Other: _____
☐ HLA / HPA Antibody Investigation Molecular Request: ☐ HEA ☐ HPA ☐ HLA ☐ RHD Variant

Unit(s) Requested (Red Blood Cells)

☐ ABO Compatible Acceptable ☐ ABO Identical Required	☐ Historically Typed Units ☐ Antigen Tested Units	Unit(s Must Lack the Following Antigens:

Unit(s) Requested (Platelets)

☐ Crossmatched ☐ HLA / HPA Matched Platelet Product

RBC / Platelet Unit Requirements

ABO/Rh:	Number of Units:	Date / Time Product Needed By:
Special Requirements: ☐ CMV Negative ☐ Hgb S Negative ☐ Irradiated ☐ Other: _____		