KENTUCKY BLOOD CENTER

Reference Laboratory Request Form

3121 Beaumont Centre Circle Lexington, KY 40513
Main: (859)276-2534 ❖ Reference: (859)519-3816 ❖ Fax: (859)514-0128

Please follow these instructions carefully

IMPROPERLY LABELED SPECIMENS WILL NOT BE PROCESSED

1. Notify Reference Laboratory in advance of specimen arrival.
2. Send 24mL anticoagulated (EDTA) OR 10mL anticoagulated (EDTA) and 20mL fresh clotted blood in sterile, well stoppered, sealed test tubes. For suspected Warm Autoantibodies, 24-30mL EDTA is preferred.
   DO NOT Send specimens collected in gel separator tubes.
3. Pack specimens carefully to avoid leakage and/or breakage. Specimens should be packed in a leak-proof container and a box.
4. Specimens should be packaged and transported according to Department of Transportation Regulations for clinical specimens.
5. **If specimens will be in transit for more than 4 hours they should be packed as you would red blood cell components.**
6. If ABO/Rh history is unknown (i.e. due to an ABO discrepancy), an ABO confirmation tube with a different collection date/time will be required prior to issue of crossmatched products.
7. **THE INFORMATION ON THIS FORM MUST MATCH THE TUBES.**
8. **MISLABELED SPECIMENS WILL NOT BE TESTED –**
   Specimens will be used for crossmatch if necessary, and MUST be legibly and clearly labeled with:
   - ❑ **The full name of the patient**
   - ❑ **Hospital ID number, SSN or DOB.**
   - ❑ **The DATE (Month, day, and year) and TIME the specimen was collected.**
   - ❑ **Phlebotomist's initials, name, or identifier.**

- For Transfusion Reactions: send clearly labeled pre- and post-transfusion specimens along with a sample of the unit(s) transfused.
  Additional form required: KBC-106 Transfusion Reaction Investigation OR *KBC-396 TRALI Investigation Report*
- For Crossmatch problems: send patient specimen along with sample of incompatible units of blood, labeled appropriately.
- For hemolytic disease of the newborn (HDN): send appropriately labeled specimens from baby, mother, and father (if available).
- FOR EMERGENCY RELEASE OF UNCROSSMATCHED BLOOD SEND TUBES WITH KBC-264 AND KBC-144

PRINT OR TYPE ALL INFORMATION - BOTH SIDES of this form MUST BE COMPLETED.

REQUIRED INFORMATION			
	NAME OF HOSPITAL/LABORATORY:		ORDERING PHYSICIAN:
	PATIENT'S NAME (Last, First):		DOB:
	HOSPITAL ID:	H/H or Plt Count:	CLINICAL DIAGNOSIS:
	DATE/TIME SPECIMEN COLLECTED: _____/_____/_____ _____:_____		PHLEBOTOMIST'S INITIALS/ID:
PATIENT RACE:	SSN:		PATIENT GENDER:
FORM COMPLETED BY/DATE:			HOSPITAL PHONE NUMBER:

COMPLETE ADDITIONAL PATIENT HISTORY ON THE BACK OF THIS FORM

SAMPLE COMPLETION PRIORITY (✓):	TESTING REQUESTED (✓):	COMPONENT NEEDED	SPECIAL NEEDS (✓):
❑ STAT (Ex. Orders for IMMEDIATE transfusion, patient is critical) Who Approves the Call-in-Fee? _____ ❑ ASAP (Ex. Orders to transfuse soon, but patient is stable) ❑ ROUTINE (Ex. patient is stable/outpatient, no transfusion orders)	❑ Antibody Identification ❑ Pre-DARA work-up ❑ Antibody Titration ❑ TXFN RXN Investigation ❑ Direct Antiglobulin Test ❑ ABO/Rh Typing Resolution ❑ Molecular Genotype ❑ HDN Investigation ❑ Other:	❑ Leukocyte Reduced Packed Red Blood Cells ❑ Crossmatched OR ❑ Compatibility Screened ❑ Antigen negative ❑ Transfusable Plasma ❑ Cryoprecipitate Pool ❑ Platelet, Pheresis **Component Quantity (✓):** ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑_____	❑ Irradiation ❑ CMV Seronegative ❑ HLA Selected-IRRADIATED ❑ Washed ❑ Designated Donor ❑ Other:

Patient Name (Last, First)		Patient ID:	

PATIENT HISTORY

Sent to KBC Before? ❑ YES ❑ NO

A complete transfusion history is vital to accurate results.

Please consult with patient, patient's family and/or patient's physician to verify transfusion history

Patients with unknown history will be treated as if they are recently transfused and may incur additional testing and costs.

Please include information obtained from other hospitals if patient has been transferred from another facility. Leave areas blank if not applicable.

PATIENT/FAMILY CONSULTED: ❑ YES ❑ NO	HAS THE PATIENT HAD PRIOR TRANSFUSIONS? ❑ YES ❑ NO ❑ Unknown

TRANSFUSION HISTORY AT CURRENT FACILITY:

NUMBER OF UNITS:	MOST RECENT DATE(S) TRANSFUSED: *(If within the last 3 months, approval for molecular genotyping?* ❑ YES ❑ NO/
ABO/RH OF UNITS *(If within the last 3 months)*	REACTION(S), IF ANY:

LIST ANY OTHER FACILITIES IN WHICH THE PATIENT HAS RECEIVED TREATMENT:

ANTIBODIES:	ANTIBODIES IDENTIFIED:
	DATE OF LAST WORKUP:

DRUGS/MEDICATIONS-Please list ALL medications the patient has received within the last 6 months. If necessary attach extra sheets. Please include if patient is receiving Darzalex/daratumumab (DARA), Win Rho or similar IgG immune globulin medication. Attach sheets if needed.

❑ See attached list

PREGNANCIES:

Has the patient ever been pregnant?	❑ Yes	❑ No	❑ Currently Pregnant/Delivering
Is there a history of Hemolytic Disease of the Newborn?	❑ Yes	❑ No	# of Pregnancies:
Pregnancy Dates:			
Has the patient ever received Rh Immune Globulin? ❑ Yes ❑ No	When?		

SEROLOGICAL RESULTS

Please give us YOUR serological findings. Indicate strength of reactions seen MACROSCOPICALLY (1+, 2+, etc.) or microscopically.

ABO/Rh (D) TESTING: Is there difficulty in ABO grouping? ❑ Yes ❑ No Is there difficulty in Rh typing? ❑ Yes ❑ No

Forward Type							Reverse Type			Direct Antiglobulin Test (DAT) ❑ Poly ❑ IgG ❑ C3
Anti-A	Anti-B	Anti-A,B	Anti-D	Rh Ctrl	Anti-D (AHG)	Rh Ctrl (AHG)	A1 Cells	B Cells		

ANTIBODY SCREEN

(Please attach copies of your antigram with screen/panel results)

Screen Cell Manufacturer: Lot #

Method: ❑ Gel ❑ Solid Phase ❑PeG ❑LISS ❑ Other:

	IS	37°C	AHG	GEL/Solid Phase
SCI				
SCII				
SCIII				
Auto				

CROSSMATCHES:

Method: ❑ Gel ❑ Solid Phase ❑ PeG ❑ LISS ❑ Other:

IS	37	AHG	GEL/Solid Phase

NUMBER OF UNITS CROSSMATCHED:

NUMBER OF UNITS INCOMPATIBLE:

COMMENTS OR QUESTIONS:

KBC USE ONLY eLog ❑

Date/Time Received:

Sample Acceptable? ❑ Yes ❑ No Tech: _____ Tech:_____