KBC-144 Reference Lab Request Form R05/24 User's Guide

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: 1		ORDERING PHYSICIAN: 2	
PATIENT'S NAME (Last, First): 3		DOB: 4	
HOSPITAL ID: 5	H/H or Plt Count 6	CLINICAL DIAGNOSIS: 7	
DATE/TIME SPECIMEN COLLECTED: 8 ___/___/___ ___:___		PHLEBOTOMIST'S INITIALS/ID: 9	
PATIENT RACE: 10	SSN: 11	PATIENT GENDER: 12	
FORM COMPLETED BY/DATE: 13		HOSPITAL PHONE NUMBER: 14	

COMPLETE ADDITIONAL PATIENT HISTORY ON THE BACK OF THIS FORM

SAMPLE COMPLETION PRIORITY (✓):

- ❑ STAT 15
  (Ex. Orders for IMMEDIATE transfusion, patient is critical)
  Who Approves the Call-in-Fee? 15a
- ❑ ASAP
  (Ex. Orders to transfuse soon, but patient is stable)
- ❑ ROUTINE
  (Ex. patient is stable/outpatient, no transfusion orders)

TESTING REQUESTED (✓):

- ❑ Antibody Identification
- ❑ Pre-DARA work-up
- ❑ Antibody Titration 16
- ❑ TXFN RXN Investigation
- ❑ Direct Antiglobulin Test
- ❑ ABO/Rh Typing Resolution
- ❑ Molecular Genotype
- ❑ HDN Investigation
- ❑ Other:

COMPONENT NEEDED

- ❑ Leukocyte Reduced Packed Red Blood Cells 17
  - ❑ Crossmatched OR
  - ❑ Compatibility Screened
  - ❑ Antigen negative
- ❑ Transfusable Plasma
- ❑ Cryoprecipitate Pool
- ❑ Platelet, Pheresis

Component Quantity (✓): 17a
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ ____

SPECIAL NEEDS (✓):

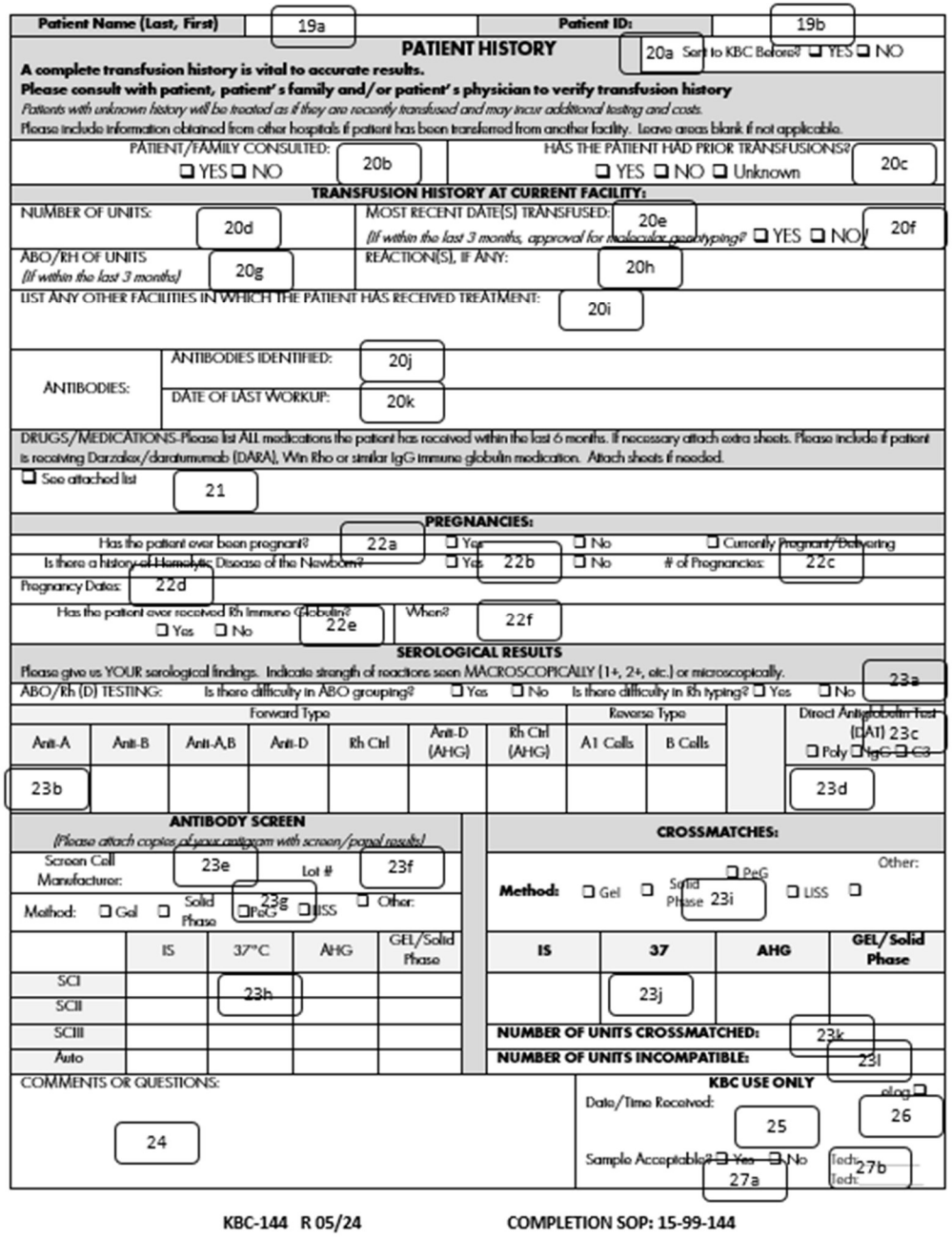
- ❑ Irradiation
- ❑ CMV Seronegative
- ❑ HLA Selected-IRRADIATED
- ❑ Washed
- ❑ Designated Donor
- ❑ Other: 18

KBC-144 R 05/24 COMPLETION SOP: 15-99-144

To be completed by Transfusion Facility (Front)

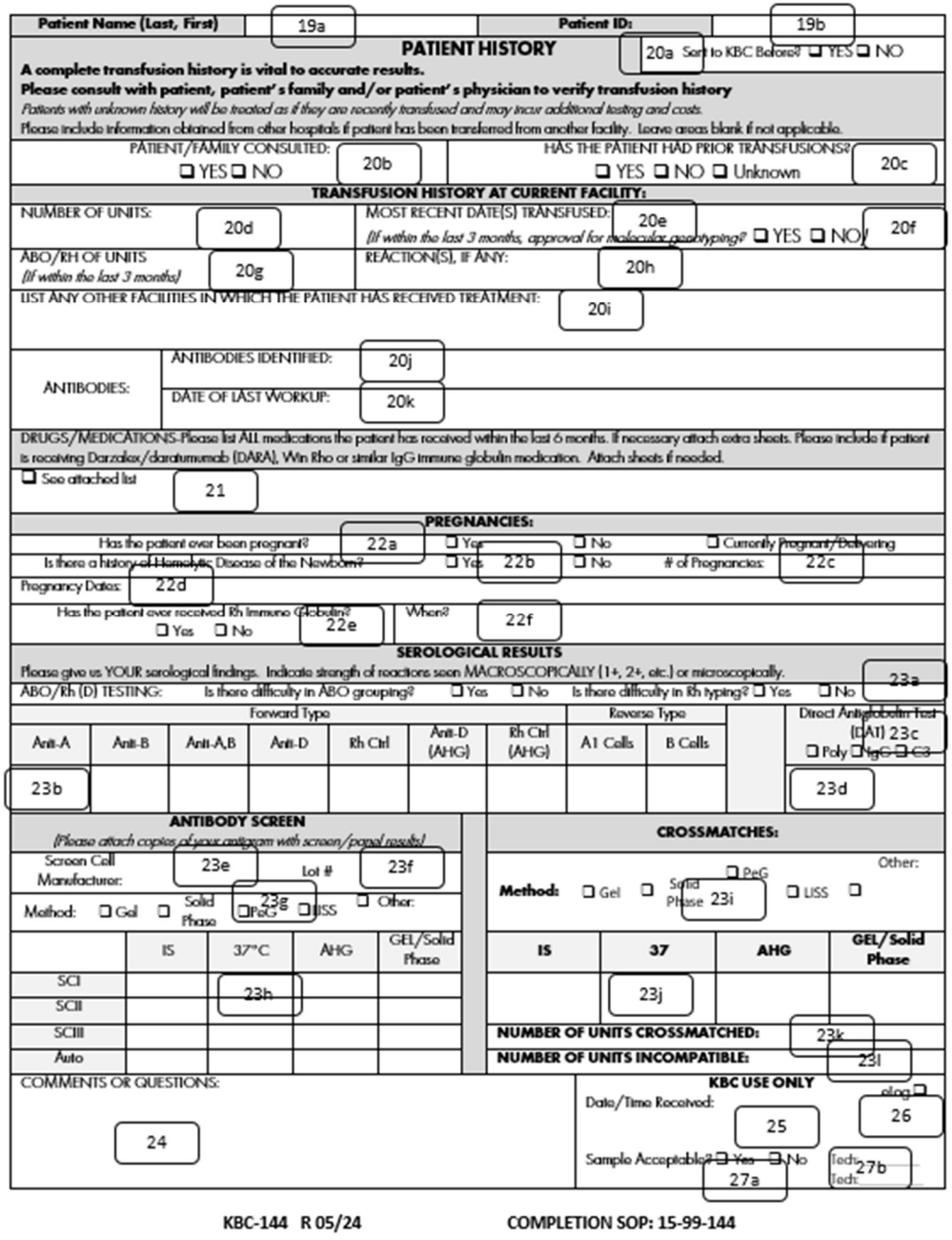
1. Name of the hospital/laboratory
2. Name of the ordering Physician
3. Patient's last name, first name (middle initial is optional)
4. Patient's date of birth (DOB)
5. Patient's hospital number/ID
6. Patient's hemoglobin/hematocrit (H/H) or Platelet Count
7. Patient's clinical diagnosis
8. Date and time specimen collected
9. Phlebotomist initials/ID
10. Patient's race
11. Patient's Social Security Number (SSN)
12. Patient's gender — Male or Female
13. Form completed by and date of completion
14. Phone number of hospital/laboratory
15. Check the Sample Completion Priority for the status of patient sample — STAT, ASAP, Routine. Examples are provided
    a. Document the name of the person approving the call-in-fee
16. Check the Testing Requested. If other is marked document the type of work-up on the blank line.
17. Indicate the Component Needed by marking the quantity desired, if applicable.
    a. Check the component quantity needed. If other is marked document the quantity on the blank line.
18. Check Special Needs, if applicable. If other is marked document the special need on the blank line.

KBC-144 Reference Lab Request Form R05/24 User's Guide



19. Document patient information:
    a. Document the Patient Name (Last, First)
    b. Document the Patient ID
20. For patient history document as follows:
    a. Check (✓) YES or NO to indicate if the patient has been sent to KBC before.

    NOTE: If the patient has been sent to KBC before, and there have been no changes to the history (transfusions, drugs or pregnancies), skip to number 22.
    b. Check (✓) YES or NO to indicate if the patient or their family was consulted for history.
    c. Check (✓) YES, NO or UNKNOWN to indicate if the patient has received prior transfusions.
    d. Document the number of units transfused
    e. Document the most recent date(s) of transfusion
    f. If the patient has been transfused in the last 3 months, check (✓) YES or NO to indicate if a sample can be sent for molecular genotyping.
    g. Document the ABO/Rh of any units transfused in the last 3 months.
    h. Document any known transfusion reactions.
    i. Document any facilities that have treated the patient and may have given transfusions.
    j. List any known antibodies identified
    k. Document date of last workup
21. List current medications, if applicable.
    a. If a list is attached, check (✓) see attached.
22. Complete the patient's pregnancy information, if applicable.
    a. Check (✓)YES or NO to indicate if the patient has ever been pregnant. Check (✓) the box if they are currently pregnant or delivering.
    b. Check (✓) YES or NO to indicate if there is a history of Hemolytic Disease of the Newborn (HDN).
    c. Document the number of pregnancies.
    d. Document the date(s) of pregnancy(ies).
    e. Check (✓) YES or NO to indicate if the patient has received Rh Immune Globulin (RhIG).
    f. Document the date of RhIG administration, if applicable.



23. Serological Results:
    a. Check (✓) YES or NO to indicate if there is difficulty in ABO group or Rh type testing.
    b. Document the serologic results for ABO/Rh
    c. Check (✓) Poly, IgG or C3 to indicate which reagent was used for the DAT testing, if applicable.
    d. Document the results of the DAT, if applicable.
    e. Document the manufacturer of the screen cells being used.
    f. Document the lot number of the screen cells being used.
    g. Check (✓) Gel, Solid Phase, PeG, LISS or Other to document the method of testing for antibody screen. If Other, document the method of testing.

    NOTE: A copy of the antigram for the cells tested should be included.

    h. Document the serologic results for the antibody screen.
    i. Check (✓) Gel, Solid Phase, PeG, LISS or Other to document the method of testing for crossmatches, if applicable.
    j. Document the serologic results for crossmatched units, if applicable.
    k. Document the number of units crossmatched, if applicable.
    l. Document the number of units incompatible, if applicable.

24. Document any additional Comments or questions.