

**REQUEST FOR REFERENCE LABORATORY STUDIES**

**Patient's Name:** \_\_\_\_\_ **Patient's MRN #:** \_\_\_\_\_  
Last Name First Name Middle Name  
 ABO/Rh(D) Type: \_\_\_\_\_ Gender:  Male  Female DOB: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_ Blood Bank Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Blood Bank Fax #: \_\_\_\_\_  
 Individual Submitting Request: \_\_\_\_\_ Requesting Physician: \_\_\_\_\_

**Date Specimen Collected:** \_\_\_\_\_ **Urgency of Request:**  Code 1 (STAT)  Code 3 (Routine) – Desired date: \_\_\_\_\_  
 Specimen Type:  Peripheral  Pre-Transfusion  Post-Transfusion  Donor Sample  Cord Blood  Others: \_\_\_\_\_

**CLINICAL STATUS AND HISTORY**

Clinical Diagnosis: \_\_\_\_\_ Medications: \_\_\_\_\_  
 Rhlg given?  N/A  No  Yes, date administered: \_\_\_\_\_ Hgb/Hct: \_\_\_\_\_ Patient bleeding?  Yes  No  
**Transfusion History:**  Unknown  
 No record of transfusion  
 Transfused prior to the last 3 months Date/s and Product/s: \_\_\_\_\_  
 Transfused within the last 3 months Date/s and Product/s: \_\_\_\_\_  
 History of transfusion reaction/s? Date/s and Reaction type/s: \_\_\_\_\_  
**Pregnancy History:**  
 Currently pregnant?  N/A  No  Yes, due date: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_ Gravida: \_\_\_\_\_ Para: \_\_\_\_\_  
**Previous antibodies detected:**  
 Anti  -D  -C  -E  -c̄  -ē  -K  -Fy<sup>a</sup>  -Fy<sup>b</sup>  -Jk<sup>a</sup>  -Jk<sup>b</sup>  -S  -s̄  WAA  
 Others (Please specify): \_\_\_\_\_  

*Please provide copies of blood bank test results and panels, if available.*

**INVESTIGATION REQUEST**

*See back for sample requirements.*

Antibody Identification  RBC Phenotyping: Specify: \_\_\_\_\_  Platelet Antibody Screen  
 ABO Discrepancy Resolution  Molecular typing: HEA panel  Platelet Crossmatch  
 DAT/Elution  Molecular typing: RH genotype  HLA class I (A,B) Typing (Vitalant Lab)  
 Compatibility testing of Red Cells  Molecular typing: Specify: \_\_\_\_\_  HLA class I antibody screen/ID, if positive (Vitalant Lab)  
 Transfusion Reaction Investigation  Cold Agglutinin Screen and Titer  Fetal Bleed Quantitation  
 RBC Antibody Titration: Specify: \_\_\_\_\_  Thermal Amplitude Studies  Others: \_\_\_\_\_

**PRODUCT REQUEST**

**Number of units:**  **Special Requests:**  HgS Negative  CMV Negative  Irradiated  Others: \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_ **Specimen Pick-up Required:**  Yes  No (Submit form with specimen)

Called to: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Please call Reference Laboratory to notify staff of intent to submit sample: (909) 386-6858**

**FOR REFERENCE LAB USE ONLY**

Received by: \_\_\_\_\_ Sample acceptable?  Yes  No, specify reason: \_\_\_\_\_  
 Date/Time: \_\_\_\_\_ Notified: \_\_\_\_\_ Notified by: \_\_\_\_\_ Date/Time: \_\_\_\_\_

## INSTRUCTIONS

1. Complete Side 1 of the Request form.
2. Call (909) 386-6858 to notify Reference Laboratory of intent to submit sample.
3. Specimen Requirements (also include pre-transfusion sample, if available):

Test	Sample Required
Antibody Identification	20-30 mL of clotted blood or EDTA whole blood
Fetal Bleed Quantitation	5-7 mL of EDTA whole blood
Platelet Ab/s and Crossmatch	10-20 mL of EDTA whole blood
RBCs Molecular Typing	5-7 mL of EDTA whole blood
HDN Evaluation	Mom: 10 mL of clotted blood or EDTA whole blood Baby: 2-5 mL cord blood and/or venous blood
Other	Contact Reference Laboratory

4. Blood sample labels should contain the following:
  - a. Patient's full name (Last, First, Middle Initial)
  - b. Patient Identification Number
  - c. Date of birth
  - d. Date/time specimen drawn
  - e. Initial of person drawing

Note: Specimen label **MUST** match the information on the Request Form; testing will not be performed on improperly labeled sample.

5. Transporting samples:
  - All samples must be sent in a sealed, leak-proof container marked with a biohazard sticker to comply with OSHA safety standards.
  - Samples should be shipped in a container maintaining a temperature between 1 to 10°C.
6. Send the Request Form with the samples to LifeStream, ATTN: Reference Laboratory:

384 W. Orange Show Road  
 San Bernardino, CA 92408  
 Phone:(909) 386-6858  
 Fax: (909) 386-6849