

# Immunoematology Consultation Request

Reference Lab contact numbers: **Phone: 215-451-4176 Fax: 215-451-2522**

See page 2 for instructions, sample types and tube labeling requirements

## 1 Call Reference Laboratory before sending sample

Reference Lab person contacted: \_\_\_\_\_ Date/Time contacted: \_\_\_\_\_

## 2 Submitting Facility Information

Facility Name/ID: \_\_\_\_\_ Request Date: \_\_\_\_\_  
Facility Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Blood Bank Contact: \_\_\_\_\_  
Blood Bank Phone #: \_\_\_\_\_ Requesting Physician: \_\_\_\_\_  
Blood Bank Fax #: \_\_\_\_\_

## 3 Patient Information

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_  
Birth Date/Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: **M**  **F**   
Specimen Date: \_\_\_\_\_ ABO/Rh: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Hgb/Hct: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Additional information: \_\_\_\_\_

Transfusion History: **No record**   
Within last 3 months: **No**  **Yes**  ► **Dates / products:** \_\_\_\_\_  
Prior to last 3 months: **No**  **Yes**  ► **Dates / products:** \_\_\_\_\_  
Pregnancy History: **Number:** \_\_\_\_\_ **Currently pregnant?** **No**  **Yes**  ► **Due date:** \_\_\_\_\_  
Known RBC antibody(ies) Anti -D  -C  -c  -E  -e  -K  -Fy<sup>a</sup>  -Fy<sup>b</sup>  -Jk<sup>a</sup>  -Jk<sup>b</sup>  -S  -s   
Other (list): \_\_\_\_\_

## 4 Test Request:

- After hours work approved: M-F 11pm to 7 am; Saturday and Sunday (after hours charges may be applied)
- Life Threatening (Case will be referred to ARC Physician for discussion)
- Transfusion ordered # units \_\_\_\_\_ Date/Time transfusion needed \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) \_\_\_\_\_ hrs
- Bleeding

<b>Investigation Requested:</b> (Check all that apply)		
<input type="checkbox"/> ABO/Rh typing <input type="checkbox"/> Positive DAT <input type="checkbox"/> Antibody identification <input type="checkbox"/> Red Cell Phenotyping	<input type="checkbox"/> Incompatible crossmatch <input type="checkbox"/> Suspected transfusion reaction <input type="checkbox"/> Hemolytic Disease of the Fetus & Newborn <input type="checkbox"/> DAT negative AIHA Investigation <input type="checkbox"/> Special Antiglobulin Testing	<input type="checkbox"/> IgA Testing (both IgA and Anti-IgA) <input type="checkbox"/> IgA only <input type="checkbox"/> Anti-IgA only <input type="checkbox"/> Monocyte Monolayer Assay(MMA)
<b>OTHER SPECIFY:</b> _____		
<b>Products Requested for this patient:</b> (Check all that apply)		<b>Product Attributes:</b> (Check all that apply)
Do not use this form as an order for blood products.	<b>Other Specify:</b> _____	<input type="checkbox"/> CMV-negative <input type="checkbox"/> Leukoreduced <input type="checkbox"/> Irradiated <input type="checkbox"/> Hemoglobin S Negative RBC <b>Other Specify: NA</b>
Fax order for blood products if transfusion is required (64.TS104.2/frm3).		

## 5 Summary of Antibody Testing Results: Please provide copies of blood bank test results.

## Immunoematology Consultation Request

### Instructions for submitting samples for a Reference Laboratory investigation:

1. Obtain an appropriate sample and label it according to the instructions in the table below.
2. Prepare the sample for shipping according to the instructions in the table below.

#### Sample and Tube Label Requirements

##### Sample Type:

Antibody Identification

Two-10mL clot tubes

Two-7mL EDTA tubes, (If warm autoantibody please submit

Four-7mL EDTA tubes)

DAT Negative AIHA Investigation:

One 7mL EDTA whole blood

Monocyte Monolayer Assay(MMA):

4.0mL serum only

For MMA studies if more than 1 antibody is present please state which antibody is to be assessed.

IgA testing:

2.0mL serum ( For all testing)

Contact Reference lab for sample requirements for any special testing not listed.

No special preparation of the patient is needed prior to collecting samples

##### **Shipping Instructions:**

**Ship to:**

**American Red Cross Penn-Jersey Region**

**ATTN: Reference Lab**

**700 Spring Garden Street**

**Philadelphia, PA 19123**

##### Label Requirements:

Sample Label **MUST** include:

- **Patient Name (Last, First)**
- **Patient ID Number**
- **Date Collected**

**NOTE: Samples not labeled with minimum requirements listed above will not be tested.**

3. Complete the form on the reverse side.
4. Contact the reference lab at the phone number on the top of the form prior to sending the sample.
5. Record the name of the person contacted and the date and time of the notification.
6. Follow any additional instructions noted in the ARC Facility-specific area below.
7. Submit the sample and a completed Consultation Request to the ARC.

##### **Facility Specific area** (for ARC use)

Please note in Investigation Request section "Other Specify" line if any testing is not to be performed, or if different enhancement media is requested.

**Please provide copies of blood bank test results.**