American Red Cross
Penn-Jersey Region
Philadelphia, PA 19123
Molecular Blood Group and Platelet Testing Laboratory
Phone #: 215-451-4917
Fax #: 215-451-4925

Effective Date:
April 27, 2004

REQUEST FOR MOLECULAR TESTING

PRINT ALL REQUESTED INFORMATION

PATIENT INFORMATION:

Last Name________________________________First Name______________________________M.I.__________
Patient ID#_______________Diagnosis:_________________________________DOB:_____________________
Gender: M F Race:___________________________ OB history:_________________________________
Date and Time of Sample Collection:____
Brief Transfusion History: ____
Antigen Typing*: ____
Antibody ID*: ____
*Please, include copies of reference workup.

PRENATAL GENOTYPING FOR HDN

MOTHER:
Sample type: ☐ Blood ☐ Amniocytes

FATHER:
Last Name________________________________First Name______________________________M.I.__________
DOB: _____________ Race________________Serologic type: ____

Comments: ____

SENDING INSTITUTION INFORMATION:

Hospital Name:____ Hospital Code:____________________
Contact person:____ Phone #:________________________
Ordering Physician:____ Phys. Ph.#_______________________

SPECIAL REQUESTS:
☐ Phone Results to:____________________________________ Phone #:________________________
☐ Fax Results to:______________________________________ Fax #:__________________________
☐ Email preliminary to: ____________________________________

TESTING REQUESTED:

SAMPLE REQUIREMENTS ON REVERSE SIDE.

RED CELL:
☐ Dombrock; Do^a, Do^b
☐ Kell; K, k
☐ Kell; Js^a, Js^b
☐ Duffy; Fy^a, Fy^b, Fy^x, Duffy Null (GATA box mutation)
☐ ABO system
☐ Kidd; Jk^a, Jk^b
☐ MNS; S,s
☐ MNS; M, N
☐ Rh system
☐ OTHER ______________________________

PLATELET:
☐ HPA-1a/1b ($PL^{A1/A2}$)
☐ OTHER ____

FORM COMPLETED BY:____________________________________DATE:___________

SAMPLE REQUIREMENTS AND SHIPPING INFORMATION

All samples **must** be clearly labeled with full name of the individual and ID#. Sample labels should also include date and time of collection.

Sample requirements:

7-10ml EDTA (lavender top) or ACD type A (yellow top) whole blood tube

Restrictions:
If patient has been transfused, please, wait 24 hours before drawing sample.
Lithium heparin sample tubes are **NOT** acceptable for testing.

Shipping requirements:

Ship all samples at room temperature or refrigerated using ice packs or wet ice sealed in plastic bags.

Wrap whole blood samples in absorbent materials to safeguard from freezing.

Ship Next Day delivery.

Shipping Address:

Molecular Blood Group and Platelet Testing Laboratory
American Red Cross Blood Services
700 Spring Garden Street
Philadelphia, PA 19123
Laboratory Phone #: 1-215-451-4917
Fax #: 1-215-451-4925