

IMMUNOHEMATOLOGY REFERENCE LABORATORY REQUEST FORM

Orlando Reference Lab:
Phone: 407-226-3824
Fax: 407-226-3830

Lake Park Reference Lab:
Phone: 561-845-2323 ext. 1236
Fax: 561-472-3925

INSTRUCTIONS

1. Antigen Negative orders only: Complete fields 1-5 and fax to the appropriate Reference Laboratory.
2. Antibody Workups:
 - Complete fields 1-11 and fax to the appropriate Reference Laboratory.
 - Label tubes with patient's full name, Medical Record or Permanent ID #, date drawn and phlebotomist's initials. Information on the tubes **must** match information on the Request form.
3. Fax the request form and call the Reference Laboratory in your service area to inform the lab of the order/samples.
 Note: Request and samples arriving after 9:00 pm Monday through Friday, weekends and holidays will be worked up on an emergency as needed basis. A STAT fee will be charged for these cases.

Specimen Requirements: Antibody Workup – 3 large EDTA (30 ml blood)
 HDN Workup – EDTA Cord Blood / Baby sample and Mother's EDTA sample
 Transfusion Reaction Workup – Pre and Post EDTA Transfusion samples
 Send the bag and tubing if available or labeled segments from the transfused unit(s).

Type and Crossmatch – 1 EDTA and 1 Red Top (No Gel separator) – Lake Park only

NOTE: Samples must be properly labeled and request form completely filled out or testing cannot be performed.

Hospital/Facility : _____
 Hospital Phone Number: _____ Facsimile Number: _____
 Requesting Technologist: _____ Date Submitted: _____

1. Patient Name: _____ Race: _____ Sex: _____
2. Medical Record #: _____ SS #: _____ DOB: _____
3. ABORh: _____ Historical Antibodies: _____ Previously submitted? Y / N
4. Blood Products and Quantity: _____ Date and Time needed: _____
5. Special Instructions:
 - CMV neg Irradiated Hgb S neg Leukoreduced Washed
 - RBC Ag neg for: _____
6. Additional order comments: _____
7. Date Sample Drawn: _____ Current Hgb /Hct: _____ Plt count: _____
8. Transfusion History: Has the patient received any transfusions at your facility or elsewhere? ___ NO ___ YES (fill in line 9)
9. Transfusion date(s) / quantity: _____
10. Diagnosis: _____ Pregnancies: _____ RhIG (if applicable) Date: _____
11. Physician: _____ Medications: (Attach Hospital Medication List.)

Serological problem - please submit copies of all panels, other serological testing performed and the DAT results.

