**Reference Laboratory Consultation Request**

***Mississippi Valley Regional Blood Center***

*How Life Flows Through Our Community*
*CICBC-Springfield Phone: 217-753-9443 Fax: 217-753-1123*
*St. Louis Phone: 314-291-4752 Fax: 314-291-4746*
*Davenport: Phone 563-823-4145 Fax: 563-441-1904*

**INSTRUCTIONS:** All submitted samples (including secondary tubes) MUST be labeled with the patient's full name, hospital ID number and date and time of collection. The identity of the phlebotomist can be labeled either on the specimen or on the request form. **Improperly labeled specimens will not be processed.**

**SAMPLE REQUIREMENTS:** NO GEL SEPARATOR TUBES
Red Cell Antibody Investigation: 4 EDTA tubes-7ml
HDN Investigations: 2 EDTA tubes-5ml from mother; Cord blood sample or 3 EDTA microtainers from baby
Platelet Antibody Investigation: 2 Serum sample tubes-7ml and 1 EDTA tube-7ml
Molecular Testing: 1 EDTA tube-2ml or 2 buccal swabs

Date Called:_____ Time Called:_____ Contact Person:_____

| □ STAT (patient critical; active bleeding) | □ ASAP | □ Routine | □ Specific Time/Date: _____ |
|---|---|---|---|

**HOSPITAL INFORMATION**

| Hospital Name: | | Date of Request: |
|---|---|---|
| Phone: Ext: | Fax: | Form Completed By: |
| Date/Time Sample Collected: | | Collected By: |

**PATIENT INFORMATION (please attach medication list)**

| Name( last, first, middle): | | Physician: |
|---|---|---|
| Hospital/Patient ID# | Date of Birth: | ABO/Rh: |
| Gender: □ Male □ Female | Race: □ Caucasian □ Black □ Other | Diagnosis: |
| Previous Antibodies: (RBC, HPA, HLA): | | HLA type: |
| Has the patient **EVER** been transfused? □ Yes □ No<br>If yes, date of last transfusion: | | Has the patient **EVER** been pregnant? □ Yes □ No<br>If yes, date of last pregnancy: |
| Has the patient received Rh immune globulin? □ Yes □ No If yes, date last administered: | | |

**LABORATORY TEST RESULTS (Please submit a copy of results obtained at your facility)**

| HGB: | HCT: | DAT: □ Neg □ Pos with: □ Poly □ IgG □ C3 □Gel |
|---|---|---|
| Auto Control: □ Not Tested □ Neg □ Pos | Reaction Phase: □ IS □ RT □ 37°C □AHG | |
| Antibody Detection Method: □ Gel □Solid Phase □Tube; list any potentiator used: | | |
| Reaction Strength: | AHG crossmatches : □Not Tested □Neg □Pos: _____out of ____ incompatible | |

| **RED CELL ANTIGEN/ANTIBODY TESTING** | | **UNIT (RBC) TESTING** |
|---|---|---|
| □ ABO Discrepancy Resolution | □ Antibody Titer | □ Historically Typed units |
| □ Antibody Identification | □ HDN Investigation | □ Antigen Tested Units |
| □ DAT | □ Molecular RBC Phenotype | □ Crossmatched Units (Springfield Only) |
| □ Super DAT | □Other: _____ | |
| □ Transfusion Reaction Investigation | | |

| **PLATELET TESTING** | **UNIT (PLATELET) TESTING** |
|---|---|
| □ HLA and Platelet-Specific Antibody Screen and Identification | □ Crossmatched Platelets |
| □ Molecular HLA Phenotype | □ HLA Matched/Mismatched Platelets |
| □ Molecular HPA Phenotype | □ HPA Matched/Mismatched Platelets |

**PRODUCT REQUIREMENTS**

| ABO/Rh: | Antigen(s) Units Must Lack: | Number of Units: |
|---|---|---|

| □ CMV Negative | □ Hgb S Negative | □ Irradiated (ALL Best Platelet Products Will Be Irradiated) | □ Washed |
|---|---|---|---|