Laboratory testing performed by Memorial Blood Centers
Phone: 651-332-7125
Fax: 651-332-7008
CLIA #24D0663800

INNOVATIVE BLOOD RESOURCES

REQUEST FOR REFERENCE LABORATORY TESTING

Complete information **must** accompany each specimen. Improperly labeled specimens will **not** be processed.

Date		Hospital/Lab			
Ordering Priority		City/State			
Ordering Physician		Phone	( )	Fax	( )

TEST REQUEST

- ❑ ABO/Rh typing
- ❑ Antibody Screen/Identification
- ❑ Antibody Titration
- ❑ Direct Antiglobulin Test
- ❑ Elution
- ❑ Hemolytic Disease of the Newborn Investigation
- ❑ Serological Phenotype _____
- ❑ Transfusion Reaction Investigation
- ❑ Common Red Cell Antigen Genotype
  - WBC Count: _____
  - DAT Positive: ❑ Yes ❑ No
- ❑ RHD Genotype
- ❑ RHCE Genotype
- ❑ Platelet Compatibility
- ❑ HLA antigen and antibody (sendout)
- ❑ Monocyte Monolayer Assay (sendout)
- ❑ Other _____

PATIENT INFORMATION

Patient's Name *(Last, First, Middle)*:					
Identifying #:		Date of Birth:		Ethnicity:	Gender:
Sample date, time and collecting individual: *(Sample noted here will be used for crossmatch, if applicable)*				# of tubes_____	
Date, time, and collecting individual for **each supplementary tube** submitted:				# of tubes_____	
Location: ❑ Inpatient ❑ Outpatient		Hgb/Hct:		Blood type:	
Historical antibodies:		Antibodies identified on current sample:			
Describe current transfusion problem and/or reason for submitting					
Test method(s), phase(s),and number of cells where positive reactions observed:					
Auto Control Positive? ❑No ❑ Yes	DAT: ❑ Not performed ❑ Negative ❑ Positive Polyspecific ❑ Positive IgG ❑ Positive Complement				

CLINICAL HISTORY

Clinical diagnosis:	
Medications:	
Has the patient been treated with immunoglobulin-based therapy in the last 6 months?	❑ No ❑Yes (If yes, please check one below)
❑ Anti-CD38 ❑ Anti-CD47 ❑ Anti-CD20 ❑ CTLA ❑ IVIG ❑ Daratumumab ❑ Isatuximab ❑ MOR202 ❑ Rituximab	Date of Last Dose:
Transfusion: ❑ Unknown ❑ No ❑ Yes, Date of most recent and number of RBC in past 3 months:	
Transplant: ❑ Unknown ❑ No ❑ Yes, date of transplant: ❑ Autologous ❑ Allogeneic	
Pregnancy: ❑ No ❑ Yes, estimated date of delivery:	Number of previous pregnancies:
Has patient received Rh immune globulin in the past 6 months?	❑ No ❑ Yes, date received:

UNIT REQUEST

Blood Bank unique identifier:		Date and time needed by:		# of units requested:	
Special Requirements:	❑ Irradiated ❑ RH (C,c,E,e) & Kell Matched	❑ HgbS Negative ❑ Kell Matched	❑ CMV Negative ❑ Phenotypically Matched		
Leukocyte-reduced RBC ❑ Crossmatched ❑ Antigen Negative (clinically significant historical and current antibodies)			Platelet ❑ Crossmatched ❑ HLA Matched		

LABELING REQUIREMENTS

All samples referred for crossmatching and pretransfusion testing must meet the current Standards of the AABB regarding recipient blood samples. Sender will be notified if a sample is unacceptable; a new sample will be required.

1. Patient First and Last Name
2. Patient Identifying Number (Date of Birth not acceptable)
3. Date and Time Sample Collected
4. Phlebotomist Identity (initials)
5. Blood Bank Unique Identifier **crossmatch**

SPECIMEN REQUIREMENTS

Specimens collected in gel-type separation tubes are unacceptable.
Specimen may be rejected if quantity is projected to be insufficient for testing.

TEST	SAMPLE REQUIRED
ABO and Rh Typing	5-10 mL EDTA whole blood or clotted blood
Antibody Screen/Identification and Compatibility Testing	10-20 mL EDTA whole blood and 7 mL clotted blood; If patient has a positive direct antiglobulin test (DAT) include a 10-20 mL EDTA tube
Direct Antiglobulin Test	5-10 mL EDTA whole blood
Elution Study	10-20 mL EDTA whole blood
Hemolytic Disease of the Newborn Investigation	Mom: 10 mL clotted blood or EDTA whole blood; Baby: 2-5 mL EDTA cord blood
HLA Antigen and Antibody	10 mL EDTA whole blood and 7 mL clotted blood
Molecular	5 mL EDTA whole blood
Monocyte Monolayer Assay (MMA)	5 mL EDTA whole blood and two 7 mL clotted blood
Platelet Compatibility/Crossmatch	10-20 mL clotted blood or EDTA whole blood; sample must be submitted within 48 hours of collection. Samples received and frozen within 48 hours are acceptable for 7 days
Transfusion Reaction	10-20 mL clotted blood or whole blood EDTA and segments from implicated donor unit(s)

DIRECTIONS FOR SAMPLE TRANSPORT

Ship samples at ambient temperatures unless temperatures are >82F or <32F.
If ambient temperature is >82F, ship samples with coolant.
If ambient temperature is <32F, ship samples in insulated container.

STAFFING HOURS

Memorial Blood Centers' Immunohematology Reference Laboratory (IRL) is staffed from 6:00 AM Monday to 10:00 PM Friday. During these hours, contact the lab at 651-332-7125. The IRL staff is on-call from 10:00 PM to 6:00 AM Monday through Friday, weekends and holidays. For after-hours requests, call Hospital Services at 651-332-7108 and ask for the Reference Lab On-Call Technologist.