Request for Blood Bank Consultation- (Client Services, please deliver all content to blood bank)

1. Contact MercyOne North Iowa by calling (641) 428-7256
   Tech requesting consultation: _____
   MercyOne North Iowa tech contacted _____
   Form Faxed to Blood Bank Fax: 641-428-6413: _____

2. Sample Requirements:

Crossmatch:	1 – Pink (6 mL) top tubes
Antibody ID:	2 – Pink (6 mL) top tubes
Crossmatch & Antibody ID:	2 – Pink (6 mL) top tubes
Antibody Screen with possible ID	2 – Pink (6 mL) top tubes
HDN:	Send cord blood + maternal sample
Transfusion Reaction:	Send pre- & post- transfusion samples and donor segments

(Retain Adequate specimen at your facility for crossmatch verification.)

3. Label all tubes with patients full name, date of birth, date/time drawn, and initials of phlebotomist.
4. Any segments submitted should be labeled with a blood unit number sticker. One segment per unit will be adequate.

Specimens from patients with the following previously identified antibodies are acceptable to send to MercyOne North Iowa Medical Center for Antibody ID.

Anti-E, Anti-K, Anti-D, Anti-C, (Anti-D and Anti-C), (Anti-D and Anti-E)

Patient Information

Patient's Name: _____ Unique Identifier: _____

Sex: _____Birthdate: _____ Requesting Facility: _____

Test (s) Requested

○ Antibody Screen- antibody identification will be ordered and charged only if the screen is positive.

○ Probable passively transferred RHIG. **ORDER: Antibody Screen**
(Include in "**CLINICAL HISTORY**" Documentation of negative prenatal screen, RHIG injection during current pregnancy, and Positive post delivery antibody screen.)
History of most recent Negative antibody screen :_____

History of most recent Rhogam injection: _____

⬭ Antigen Typing of Units – antigen testing on the following: Anti-D, C, E, K.

⬭ Crossmatch / Compatibility Testing
A. How many packed cells are needed? _____
B. When are they needed? _____
C. Segments sent: _____

⬭ Hemolytic Disease of Newborn Testing

⬭ Transfusion Reaction Investigation

Clinical History

ABO/RH on file: _____

Previously identified antibodies: _____

Studied before? _____ Where?_____

Transfused? _____When? _____ How many units? _____

Medications: _____

Diagnosis: _____

Pregnancies (#): _____ Problems? _____

Results of tests performed at hospital:

ABO: _____ RH: _____ Direct Coombs: _____***

***If the direct coombs is positive and the antibody screen is positive, refer the specimen to the LifeServe Blood Center.)

Circle the methodology used for testing: Tube Gel Solid Phase
Antibody Screen: Reaction phase(s)_____Reaction strength: _____
Specify additives used: _____

Please include a copy of your testing results if possible. Thank you.