SBMF
South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

Blood Bank Services
Telephone: 574-251-1760
Fax: 574-232-9137

BLOOD BANK EXTENDED TESTING REQUEST FORM

Please notify the Testing Laboratory (574-251-1760) before sending samples and when adding testing on existing sample

1. Fill out all requisition information as completely as possible.
2. The following information is required on each tube: patient's full name, unique identification number, collector's id and date/time of sample. Specimens without this information will be rejected.
3. The patient name and unique identification number on specimen tubes and this requisition must match or the specimen will be rejected.
4. Submit 1 clot and 2 anticoagulated (EDTA) samples. DO NOT separate serum and / or plasma. No special handling is required.

TEST REQUESTED - additional testing may be performed as required

- ☐ ABORH typing difficulty
- ☐ Antibody identification: Includes ABORh, antibody screen, antibody ID. As needed: antigen typing, DAT, elution
- ☐ Baseline phenotype: C, c, E, e, K, Fy(a,b), Jk(a,b), S, s
- ☐ OB work-up: Includes ABORh, HDN antibody screen. As needed: antibody ID, titer, antigen typing
- ☐ Titer only, Known antibody _____
- ☐ Fetal Screen (Rh typing if indicated)
- ☐ Segment Screening: Specify antigen _____
- ☐ Crossmatch screening ☐ Elution

Patient's Name: _____

Identification #: _____

Sex _____ Age _____ Race _____ DOB _____

Hospital: _____

Diagnosis: _____

Collection Date _____ Time _____

Collector's ID_____

Transfusion History (ever)? ____ Within last 3 months? _____

If Yes, when? _____ Type / # units _____

Medications: _____

Rhogam Given: Y_____ N _____ If Yes Date/Time _____

H/H _____ Pregnancy History: _____

Routine ☐ No orders for transfusion ***OR*** units are ordered on hold for future surgical procedure. Sample will not be evaluated after hours

ASAP ☐ Patient is stable but has an order to transfuse or to have units on hold. Sample may not be evaluated after hours

STAT ☐ Life threatening situation requires immediate attention and fastest transportation available.

Previous antibodies identified: _____

Do you want a preliminary report faxed? ☐ YES ☐ NO

If yes, please indicate fax number: _____

Requested by: _____

Phone # _____

Units Needed: _____

Product Special Requirements (CMV-, irradiated, Hgb S)

_____

Date/Time Products Needed: _____

Please fill out the following as completely as possible. Give strength of reactions.

Please Include Copies of All Completed Testing (Panels, Etc.)

ABO _____ Rh _____ Weak D _____

DAT: Poly _____ Anti-IgG ____ Anti-C_3d _____

ANTIBODY SCREEN RESULTS:

	RT	37°C	AGT
SCI	_____	_____	_____
SCII	_____	_____	_____
SCIII	_____	_____	_____
AC	_____	_____	_____

ENHANCEMENT:

GEL	ALBUMIN	LISS	PEG	SOLID PHASE	OTHER
☐	☐	☐	☐	☐	☐

CROSSMATCH RESULTS

COMPATIBLE _____ # INCOMPATIBLE: _____