ImpactLife Z-001: Reference Laboratory Consultation Request

Springfield:	Phone 217-753-9443	Fax 217-528-3271	**Davenport:**	Phone 563-823-8933	Fax 563-441-1904
St. Louis:	Phone 314-291-4752	Fax 314-291-4746	**Madison:**	Phone 608-590-4073	Fax 608-590-4076

Instructions: All submitted samples (including secondary tubes) MUST be labeled with the patient's full name and a unique identifier (hospital ID, BBID, DOB). The date / time of collection and identity of the phlebotomist may be labeled either on the specimen or on the request form. Improperly labeled specimens will NOT be processed.

Sample Requirements: **SEE PAGE 2**

Date Called: _____ Time Called: _____ Person Contacted: _____

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

Hospital Information

Hospital Name:	Phone: Ext:
Form Completed By:	Fax:

Patient Information ***(Please attach medication list.)***

Patient Name (Last Name, First Name):		☐ Male ☐ Female ☐ Unknown
Patient Hospital / Med Rec #:		Patient DOB:
Ethnicity:	Diagnosis:	Ordering Provider:
ABO / RH:	Previous or Known Antibodies:	
Transfused in the LAST 3 Months? ☐ Yes ☐ No ☐ Unknown		Date of LAST Transfusion:
EVER received RhIG? ☐ Yes ☐ No ☐ Unknown		Date of Last RhIG Administration:
Date / Time Sample Collected:		Collected By:
Are there current orders to transfuse? ☐ Yes ☐ No		Patient Status: ☐ In Patient ☐ Out Patient ☐ Trauma ☐ Emergency Surgery ☐ Elective Surgery

Hospital Test Results ***(Please submit a copy of results obtained at your facility.)***

H/H:	Please briefly describe obtained results:
Antibody Reactivity: ☐ Gel ☐ Solid Phase ☐ Tube	Potentiator: ☐ PeG ☐ LISS ☐ Other: _____

Type of Service Requested

☐ Full Antibody ID ☐ Labor / Delivery* ☐ HDN - Baby Workup ☐ HDN - Mother Workup

☐ Routine Prenatal* ☐ Direct Antiglobulin Test* ☐ Eluate* ☐ Antigen Type*: _____

☐ ABO Discrepancy Resolution* ☐ Other: _____

☐ HLA / HPA PLT Antibody Investigation Molecular Request: ☐ RBC Molecular Phenotype ☐ RHD Variant ☐ RHCE Variant ☐ HLA Molecular Phenotype ☐ HPA Molecular Phenotype

* Abbreviated Workup

Unit(s) Requested (Red Blood Cells)

☐ ABO Compatible Acceptable ☐ ABO Identical is Required	☐ Historically Antigen Tested ☐ Antigen Confirmed	Date / Time Product Needed By:

Special Requirements: ☐ CMV Negative ☐ Hgb S Negative ☐ Irradiated ☐ Other:_____
☐ Antigen negative for: _____

Unit(s) Requested (Platelets)

☐ First / Best Available PLT Product ☐ Crossmatched PLT Product ☐ HLA / HPA Matched PLT Product

Special Requirements: ☐ CMV Negative ☐ Hgb S Negative ☐ Irradiated ☐ Other:_____

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Sample Requirements: **NO GEL SEPARATOR TUBES (IMPROPERLY LABELED SPECIMENS WILL NOT BE PROCESSED)**	
FULL Red Cell Antibody Investigation:	4 EDTA tubes - 7mLs
Routine Prenatal Workup (Abbreviated):	2 EDTA tubes - 7mLs
Labor / Delivery (Abbreviated):	2 EDTA tubes - 7mLs
ABO Discrepancy Resolution (Abbreviated):	4 EDTA tubes - 7mLs
Antigen Type (Abbreviated):	1 EDTA tube - 7mLs
Direct Antiglobulin Test (Abbreviated):	1 EDTA tube - 7mLs
Eluate (Abbreviated):	2 EDTA tubes - 7mLs
HDN - Baby Workup:	Cord blood sample OR $\geq$ 3 EDTA microtainers
HDN - Mother Workup:	2 EDTA tubes - 5mLs
Molecular Requests:	1 EDTA tube - 2mls or 2 buccal swabs
HLA / HPA Platelet Antibody Investigation:	2 Serum tubes - 7mls (NO SST Tubes) & 2 EDTA tubes - 7mls

ImpactLife Use Only:		**NA** ☐
BloodHub Entry Completed		
Initials:	Date/Time:	BloodHub#: