

ANTIBODY REFERRAL FORM
Methodist Hospital/Children's Hospital
BLOOD BANK DEPARTMENT
8303 Dodge Street
Omaha, NE 68114
(402) 354-4562 (Blood Bank)

COLLECTION AND SUBMISSION OF SPECIMEN

1. Obtain sample and label it according to the instructions to follow:

Sample Type:

1-2 7 ml EDTA tubes (freshly drawn <24 hours old)

Do not submit samples collected in serum separator tubes

For transfusion reaction workup, include donor segments, patient's pre and post-transfusion specimens.

For Hemolytic Disease of the Newborn Investigation, collect a 7 ml EDTA tube from mother and an EDTA tube collected from baby.

Sample Label Must Include:

Patient first and last name

Patient ID number

Date time collected, initials of person drawing specimen

Note: Improperly labeled samples will not be tested

2. If the need for blood is urgent, send unit segments for antigen typing. Alternately, antigen negative blood can be requested from the American Red Cross after antibody(ies) have been identified.
3. Complete this form and contact the Blood Bank at the phone number listed above. Give them the estimated date and time of specimen arrival.

DATE & TIME CALLED: _____ PERSON CONTACTED _____

SUBMITTING FACILITY INFORMATION

Facility Name: _____ Request Date: _____

Facility Address: _____

Facility Phone: _____ Facility Fax Number: _____

Requesting Physician: _____

PATIENT INFORMATION:

Patient Name: _____ Patient ID: _____
Birth Date: _____ Race: _____ Gender: Male _____ Female _____
Specimen Date: _____ ABO/Rh _____ Hgb/Hct _____
Diagnosis _____
Medications _____
Transfusion History: No Record _____
 Within last 3 months: NO _____ YES _____ Dates/Products: _____
 Prior to last 3 months: NO _____ YES _____ Dates/Products: _____
Pregnancy History: Number: _____ Currently Pregnant? NO _____ YES _____
 Recently received RhIG: NO _____ YES _____ Date Given: _____
Known RBC Antibody(ies): _____

TEST REQUEST:

Routine _____ Patient not waiting, transfuse when available
ASAP _____ Patient waiting, transfusion needed as soon as possible
STAT _____ Patient actively bleeding/or scheduled for surgery on _____

SUMMARY OF ANTIBODY TESTING RESULTS:

Tube _____		IS	37C	AHG
	I	_____	_____	_____
	II	_____	_____	_____
	III	_____	_____	_____

Gel _____		AHG
	I	_____
	II	_____
	III	_____

If gel technology performed, send sealed gel card or Xerox copy of gel card.

Crossmatch Results:

#Compatible Donors _____
Incompatible Donors _____

DAT (or Auto Control): Positive: _____
Negative: _____