Shepeard Community Blood Center, 1533 Wrightsboro Road, Augusta, Georgia 30904	SOP #: **E124.0F**
LABORATORY REQUEST	Rev: 041123

Please fill out request COMPLETELY (Page 1 and 2) and send with specimen

PATIENT SAMPLE	LABEL
• THREE -7mL purple or pink top tubes EDTA or equiv. volume. **AND** • ONE -10mL plain red top • Serum separator tubes are not acceptable	Label each sample tube clearly and legibly • Patient's first and last name • Patient's ID or Medical Record Number (MRN) • Phlebotomist identification • Date and time collected Patient's name and ID number must match EXACTLY on sample *and* this request
IMPROPERLY LABELED SAMPLES WILL NOT BE TESTED **SHORT VOLUME (QNS) SPECIMENS MAY DELAY TESTING**	

1. NOTIFY SHEPEARD LAB TECH BY PHONE OF REQUESTED TESTING

Spoke with: _____ Date/Time contacted: _____

2. SUBMITTING FACILITY INFORMATION

Facility Name: _____ Request Date: _____ Time: _____

Requesting Tech: _____ Blood Bank Phone #: _____

Blood Bank Fax #: _____ Does your facility use an electronic patient ID system? No ☐ Yes ☐

3. PATIENT INFORMATION

Last Name: _____ First Name: _____

ID# / MRN: _____ DOB: _____ Race: _____ Gender: M ☐ F ☐

Diagnosis: _____ ABO/Rh: _____ Hgb/Hct: _____

Phlebotomist name/ID: _____ Collection date and time: _____

Medications *(attach list if necessary)*: _____

Ordering physician: _____Additional information: _____

Transfusion history: Within last 3 months: No ☐ Yes ☐ Dates/products: _____

No Record: ☐ Prior to last 3 months: No ☐ Yes ☐ Dates/products: _____

Transfusion location: _____

Pregnancy history: Number: _____ Currently pregnant? No ☐ Yes ☐ Due Date: _____

Has patient received Rh Immune Globulin in the last 3 months? No ☐ Yes ☐ Date received: _____

If Rh Immune Globulin received, which type: Rh Globulin ☐ IV IgG ☐ WinRho☐

Antibody history *(if known)*: _____

4. RESULTS OBTAINED AT YOUR LAB (*Attach copy of work-up*)

Direct Antiglobulin Test (DAT)		
Poly	Anti-IgG	Anti- C3b, C3d

Indirect Antiglobulin Test (IAT) Method used ☐ LISS-IAT ☐PEG-IAT				☐ GEL
Screening Cells	**I.S.**	37°C	AHG/CC	GEL
I / 1				
II / 2				
III / 3				
Auto				

5. TESTING REQUESTED

ABO/Rh typing ☐ DAT ☐ Antibody identification ☐

Other (specify): _____

6. PRODUCTS REQUESTED FOR THIS PATIENT

Transfusion facility *(if different from requesting facility):* _____

Antigen-Negative RBCs: # Units_____ Date/Time needed_____

Negative for: D ☐ C ☐ c ☐ E ☐ e ☐ K ☐ Fy^a ☐ Fy^b ☐ Jk^a ☐ Jk^b ☐ S ☐ s ☐

Other: _____

Product attributes: Leukoreduced (CMV safe) ☐ Irradiated ☐ Other: _____

7. WHEN NEEDED

☐ Routine (within 24 hours) ☐ Urgent/ASAP (within 12 hours) ☐ Emergency/STAT (within 8 hours)

8. SEGMENTS SUBMITTED FOR TESTING

When submitting segments for testing, please verify the following:

- If possible, two segments have been submitted for each unit
- Each segment submitted has a complete segment number
- Each segment is labeled with the corresponding whole blood number
- The table below has been completed

*** SEND SEGMENTS FROM ALL ABO/RH COMPATIBLE UNITS IN YOUR INVENTORY ***

	UNIT NUMBER	SEGMENT NUMBER	ABO/Rh
1			
2			
3			
4			
5			
6			

Attach additional page if necessary

9. REVIEW

The individual whose signature appears below verifies: (1) The information contained on this requisition is accurate; and (2) The samples being submitted are properly labeled AND are the required quantities.

Signature: _____ Date: _____

Any questions should be directed to the Technical Director or Assistant Technical Director
Phone: 706-737-4551
Fax: 706-738-1603 OR 706-842-7000
After hours on-call tech: 706-833-0202