



Community Blood Center
 Community Tissue Services
 349 South Main Street
 Dayton, Ohio 45402

Telephone: (937) 461-3450 ext. 3264
 Fax: (937) 461-2738

REFERENCE CASE REQUEST FORM

INSTRUCTIONS:

1. Please call the Reference Laboratory before sending specimens.
2. Please submit a **MINIMUM** of 7ml of **CLOTTED BLOOD** and 5ml of **ANTICOAGULATED BLOOD** (i.e. EDTA.)
3. For investigation of transfusion reaction, submit:
 - A. Sample of patient's blood before transfusion.
 - B. Sample of patient's blood after transfusion.
 - C. Unit number(s) of suspected unit(s).
4. In cases of Hemolytic Disease of the Newborn, submit samples from:
 - A - Mother
 - B - Baby (minimum of 2cc anti-coagulated blood and 1cc of serum)
 - C - Biological Father (particularly if HDN due to a low incidence antibody is suspected-EDTA only.)
5. Patient's blood samples must be sent in stoppered tubes with firmly attached labels containing the patient's first and last names, social security number and/or birthdate, and the date the tubes were drawn. (If sending samples after hours, please separate the serum/plasma from the red cells before sending.)
6. Fill out form completely and send with the blood specimens. Samples can be sent at room temperature or on wet ice. Mark container ATTN: REFERENCE LABORATORY.

Hospital		Telephone Number for Report		
Patient Name		Age	Race	Sex
Diagnosis	Physician		D.O.B. or SS No.	
Medications: (List)				
Number of Pregnancies: _____		Difficulties: _____		
Pregnant Now? _____		Date Due: _____		
Transfusion History: _____		Within Last 4 Months, Dates: _____		
_____		Prior to Last 4 Months, Dates: _____		
Previous Reaction: <input type="checkbox"/> Febrile <input type="checkbox"/> Allergic <input type="checkbox"/> Hemolytic <input type="checkbox"/> Other (describe)				
Hemoglobin/Hematocrit: Retic: Bilirubin: Platelet Count:				
Has patient previously been referred to this lab or to any other consultation lab? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, where? _____		When? _____		
Results: _____				

Nature of Difficulty (Please mark all that apply):

- | | |
|---|--|
| <input type="checkbox"/> ABO Typing problem | <input type="checkbox"/> Hemolytic Disease of Newborn (HDN) |
| <input type="checkbox"/> Rh(D) Typing Problem | <input type="checkbox"/> Unidentified Antibodies |
| <input type="checkbox"/> Incompatible Red Cells | <input type="checkbox"/> Positive Direct Antiglobulin Test (DAT) |
| <input type="checkbox"/> Suspected Transfusion Reaction | <input type="checkbox"/> Platelet Refractoriness |

Requested Tests

- Reference Case (includes antibody identification and all tests deemed necessary by the reference laboratory for complete resolution of the problem, i.e., adsorptions, elutions, associated ABO and Rh(D) typing problems, etc.)
- ABO Type only
- Rh(D) type only
- Red Cell Crossmatching; number of units: _____ (Note: separate charges for crossmatching will be applied.)
Units need to be (mark all that apply): leuko-reduced CMV neg irradiated
- Platelet Crossmatch (Please check with CBC before ordering.)
- Platelet Antibody Identification (Please check with CBC before ordering.)
- HPA-1A (PLA-1) antigen typing (Please check with CBC before ordering.)

Hospital Laboratory Findings: (Please submit copies of panel sheets and/or screening results)

Date Sample Collected _____

ABO Group _____ Rh(D) type _____ Other Phenotyping _____

DAT testing: Polyspecific _____ anti-IgG _____ anti-complement _____

Antibodies identified (including those previously identified): _____

Antibodies suspected: _____

Enhancement Used:

- Albumin LISS PEG Gel Saline Enzyme
- Other

Compatibility Tests: Positive _____ Negative _____

Comments: