

**Laboratory of Immunohematology and Genomics**

45-01 Vernon Boulevard, Long Island City, NY 11101 / Phone: 718-752-4771 / Fax: 718-752-4747

Routine  ASAP

**Life-Threatening samples must be transported (STAT) direct/non-stop**

Sample **Drawn:** \_\_\_/\_\_\_/\_\_\_  
Month Day Year

Sample **Sent:** \_\_\_/\_\_\_/\_\_\_  
Month Day Year

Please also send pre-transfusion RBC sample, if available.

**Patient Information**

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Medical Record Number \_\_\_\_\_ Previous investigation at NYBC?  Yes  No

Ethnicity (check all that apply) African-American  Asian  Hispanic  Native American  Pacific Islander  White  Other \_\_\_\_\_

**Diagnosis** \_\_\_\_\_

Hgb/HCT \_\_\_\_\_ Active bleeding? \_\_\_\_\_ Signs of hemolysis? \_\_\_\_\_ HDN? \_\_\_\_\_

Medication (if applicable) \_\_\_\_\_

**Transfusion History**

Transfusions within last 3 months? Number \_\_\_ Date(s) \_\_\_\_\_

Transfusions prior to last 3 months? Number \_\_\_ Date(s) \_\_\_\_\_

History of reactions? \_\_\_ No \_\_\_ Yes, describe: \_\_\_\_\_

Previous pregnancy? \_\_\_ No \_\_\_ Yes, date(s) \_\_\_\_\_ Stem cell transplant? \_\_\_ No \_\_\_ Yes, date \_\_\_\_\_

IVIG? \_\_\_ No \_\_\_ Yes, date(s) \_\_\_\_\_ Rh Immunoglobulin? \_\_\_ No \_\_\_ Yes, date(s) \_\_\_\_\_

**Hospital Test Results**

DAT: Poly \_\_\_\_\_ IgG \_\_\_\_\_ C3 \_\_\_\_\_ Control \_\_\_\_\_

ABO/Rh \_\_\_\_\_ Known Antibodies \_\_\_\_\_

Describe current transfusion problem and/or Reason for submitting \_\_\_\_\_

Do you have a request from a physician to transfuse this patient? \_\_\_ No \_\_\_ Yes

**Hospital Contact Information**

Ordering Physician \_\_\_\_\_ Contact Person \_\_\_\_\_

Hospital Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Hospital Address \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-mail \_\_\_\_\_

**Enclose with blood specimens and panel sheets**

**Samples needed**

Also include pre-transfusion RBC sample, if available

Patient's Situation	Type of Blood Sample
Recently Transfused	10 ml clotted and 15 ml anticoagulated
Not Recently Transfused	10 ml clotted and 7 ml anticoagulated
Autoimmune Hemolytic Anemia	10 ml clotted and 15 ml anticoagulated
Hemolytic Cold Reacting Antibodies	10 ml clotted and kept at 37°C until serum separated and 7 ml anticoagulated
*Drug-induced hemolytic anemia	10 ml clotted and 7 ml anticoagulated

\*For investigation of drug-induced hemolytic anemia, list medications and **submit relevant drug(s)**

**Blood sample labels should contain:**

1. Patient name
2. Patient identifying number (Medical Record #)
3. Date sample drawn
4. Phlebotomist identity (initials)

Insufficiently labeled samples will not be tested.

**Procedure for sending samples:**

1. **During working hours**
  - a) Fill out the Request for Serological Investigation Form and provide the necessary information
  - b) Notify the Laboratory of Immunohematology by telephoning before sending samples
  - c) Pack the sample in a secured protective manner to avoid breakage
2. **After hours (Life Threatening)**
  - a) Fill out the Request for Serological Investigation Form and provide the necessary information
  - b) Telephone your local NYBC distribution department
  - c) Order will be triaged by NYBC staff who may telephone the hospital blood bank staff to determine the urgency of the workup
  - d) Pack the sample in a secured protective manner to avoid breakage

**Delivery instructions:**

**Routine samples:** Arrange transportation either with your own courier or local NYBC distribution department

**Life-threatening samples: Arrange emergency transport direct, non-stop.**

Deliver ALL samples to the 45th Road employee entrance of the 45-01 Vernon Boulevard facility.

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