Received by Carter BloodCare
(Date and Time)

Pick Up Fee
(circle one)
YES NO

Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES REQUEST FORM

Phone: 817-412-5740 Fax: 817-412-5749

SAMPLE TYPE AND APPROPRIATE SAMPLE LABELING

R&T Services: Required Minimum Sample 14 mls EDTA (NO Serum Separator) Additional Sample 7 - 14 mls EDTA Platelet Services: 7 mL Red Top Sample

Patient Name (Last, First): ______ Sample(s) Collection Date/Time/By: ______

Patient ID: ______ Requesting Facility: ______

Ordering Physician: ______ Blood Bank ID (if applicable): ______

Order Status (Circle One)

STAT ASAP ROUTINE

To Be Delivered by Date/Time: ______

Samples were collected using a validated electronic ID system? ☐ Yes ☐ No

Date of Birth: ______ Gender (Mark One) ☐ M ☐ F ☐ Other: ______

Diagnosis: ______ Medication: ______

Transfusion History

Transfused within last 3 months NO YES UNKNOWN If yes, date of last red cell transfusion: ______

FOR CBC USE ONLY: Issued to the Distribution Department

DATE	TIME	Clerical Check	Visual Inspection	Tech 1	Tech 2

TESTING REQUESTED (Check Applicable)

______ Antibody Identification
______ ABO Discrepancy
______ Crossmatch
______ Adsorption Studies
______ Add-On Crossmatch
______ Platelet AB Screen
______ Titration Studies
______ Platelet Crossmatch
______ Fetal Hemoglobin (HgbF) - Provide Pregnancy History*
______ Direct Antiglobulin Test (DAT)
______ Elution
______ Cord Blood Workup
______ Other (specify): ______

PRODUCT REQUESTED (Indicate Number Needed)

______ LRBC(s)

Patient ABO/RH: ______

Antigen Negative (specify) ______

Substitution of ABO/RH Allowed? (Circle One) Yes No

______ APHERESIS PLATELET(s) (Cirlce One)

HLA Matched Crossmatched HPA-1a

______ RECONSTITUTED WHOLE BLOOD

Specify HCT ______ % Specify Amount ______ mls

______ Other (specify): ______

Special Instructions (Circle Applicable)

Irradiated Washed Sickle Cell Negative

CMV negative Volume Reduced

Other (specify) ______

MOLECULAR TESTING REQUESTED

3 mL untouched EDTA is required for Molecular Testing

______ RBC Genotype
______ Weak D 1, 2, 3 (RHD)
______ Partial D (RHD)
______ RHCE
______ HPA-1a
______ Other (specify): ______

Pregnancy History*

Number of Pregnancies: ______ Pregnant Now? (Circle One) Yes No

RhIG (Circle One) Yes No If yes, date of RhIG administration: ______ Due Date: ______

Please Indicate Results of your Findings

	37°C	IAT
I		
II		
III		
AUTO		

Method Used: ☐ Tube ☐ Gel ☐ Solid Phase

Direct Antiglobulin Test: ☐ Neg ☐ Pos: ______

Other (specify) ______

☐ Enclosed Worksheet with Request

HLA Matched, Crossmatch Platelet(s) Required or HPA-1a

	SUN	MON	TUES	WED	THURS	FRI	SAT
Date / Time of Expected Transfusion							
Number of Units Required							

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