Community Blood Center Administrative Offices: 4040 Main Street Kansas City, Missouri 64111
Phone: 816-968-4053 **Fax: 816-277-0757**

IMMUNOHEMATOLOGY LABORATORY REQUEST FORM

*****Patient's Name/ID _____ Birth Date _____
*Date Collected _____ *Date Submitted _____ *Sex _____
*Hospital/Facility _____
*Physician Requesting Test(s) _____
Information on test methods, performance specifications and interpretation are available on request.
*CLIA Required Information, CFR 493.1241

Clinical History: Diagnosis _____ Race _____
Prior transfusions: ☐Yes ☐ No
Date of most recent red cell transfusion _____ Number of Transfusions _____
Pregnancy: Is patient now pregnant? _____ Gravida _____ Para _____
Drug History: List or attach all medications patient is or has recently received: _____

Test Requested: ☐ ABO grouping ☐ Investigate Positive Direct Antiglobulin Test
☐ Rh typing ☐ Investigate Possible Transfusion Reaction
☐ Antibody Identification ☐ Investigate Possible Hemolytic Disease of Newborn
☐ Other (specify) _____
Patient ABO _____ Rh _____ Direct Antiglobulin Test: Poly _____ IgG _____ C' _____
Antibodies Identified: _____
Antibody Reactivity: ☐Tube Test: ☐22C ☐37C ☐IAT ☐Saline ☐LISS ☐PEG ☐Enzymes
☐Gel ☐Solid Phase Other _____
Comments: _____

Provide Units for Transfusion:
ABO/Rh: _____ Number of units _____ Antigen negative for: _____
Special Requirements: ☐ CMV-negative ☐Irradiated Other: _____
Date and time needed: _____ Urgency: ☐ Routine ☐ STAT

Please write or attach additional information on back of this form.
- Most investigations require a minimum of 14-20 mL anticoagulated blood.
- Do not submit specimens collected in gel-type separation tubes.
- Specimens must be packaged to prevent leakage and may be shipped at room temperature or refrigerated.

Date: _____ Personnel authorized to request tests/receive results: _____
FAX: _____ Telephone: _____

For CBC Use Only		
Billing Entered into El Dorado By:	Date:	
Results Reviewed by:	Date:	
Results Telephoned to Hospital To:	Date:	By:

SEND TO:

COMMUNITY BLOOD CENTER
IMMUNOHEMATOLOGY REFERENCE LAB
4040 MAIN, KANSAS CITY, MO 64111

From:_____

Ship: ☐ STAT ☐ ASAP ☐ Routine

Test: ☐STAT ☐ ASAP ☐ Routine

Please call IRL at 816-968-4053 prior to sending sample.