



# Request For Immunohematology Testing

1200 N. Highland Ave. Phone: 630-264-7832  
 Aurora, IL 60506 Fax: 630-892-8648

**Submit at least 2 (10ml) red top and 2 (7ml) purple top tubes**  
 Labeled with patient's first and last name, numerical ID, and date drawn  
 Serum separator tubes are not acceptable.

### Hospital Information

Hospital	City
Technologist	Date

### Patient Information

Last Name		First Name		M.I.
Numerical Identifier	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian	
Request <input type="checkbox"/> Antigen Screened Units <input type="checkbox"/> Antibody Identification <input type="checkbox"/> Crossmatch <input type="checkbox"/> Other	Special Products <input type="checkbox"/> CMV Negative <input type="checkbox"/> Irradiated <input type="checkbox"/> Leukoreduced <input type="checkbox"/> Washed Cells	Specificity: _____ Number of units needed: _____ Date and time needed: _____		

<b>Diagnosis:</b>	Hgb/Hct	ABO/Rh
Check below if the patient has any of the following conditions <input type="checkbox"/> Autoimmune Hemolytic Anemia <input type="checkbox"/> Oncology Patient <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Transplant Recipient <input type="checkbox"/> Lupus Erythematosus <input type="checkbox"/> Septicemia <input type="checkbox"/> Multiple Myeloma / Waldenstrom Macroglobulinemia		Number of Pregnancies

**Medication:** Attach separate sheet or list any medications or supplements the patient recently received or is currently taking:

**Transfusion History:**  Never Transfused  
 Transfused → Most recent RBC transfusion (date): \_\_\_\_\_ # of units: \_\_\_\_\_  
 Hemolytic (or other serious) Transfusion Reaction  
 Others hospitals the patients has been admitted to/ surgical history

**Laboratory Test Results:** *(Please attach a copy of the antibody screen or panel results.)*

	IS	37°C	AHG	Method (tube or gel): _____
Cell #1				Enhancement Reagent Used: _____
Cell #2				Prewarm/Cold Screen: _____
Cell #3				Summary of Panel Results: _____
Auto Ctl / DAT				

Crossmatch Results: \_\_\_\_\_ out of \_\_\_\_\_ were **incompatible**  
 Previously Identified Antibodies: \_\_\_\_\_

**Date Drawn:** \_\_\_\_\_ **Sample Submitted**  Pretransfusion  Posttransfusion  Prenatal  Cord  
 HBC Reference #: \_\_\_\_\_ Order Taken By: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_