Person Completing Requisition	
Institution	Client#
Dept	Physician
Address	
City	ST ZIP
Phone (Lab)	Phone (Physician)

ILLINOIS
IMMUNOHEMATOLOGY REFERENCE LABORATORY

Phone (630) 264-7832
Fax (630) 892-8648

Request for Antigen Negative Red Cell Unit(s)

☐ **STAT**	**Please contact Versiti partner directly when ordering STAT service**
☐ **Routine**	**Indicate date/time needed:** _____

Patient Last Name: _____ **First Name:** _____

Date of Birth: _____ **ABO/Rh:** _____ **MR#:** _____

Deliver to (if different than address listed above): _____

Unit Requirements

Number of Units requested:_____

☐ Irradiated ☐ CMV Negative ☐ Saline washed ☐ HgbS Negative

☐ Other: _____

*ABO/Rh compatible red cells may be substituted. Please contact your Versiti partner directly to request ABO/Rh specific units.

Antigen Negative for:													
Please circle or comment, what the requested unit(s) need to be antigen negative for:													
C	**E**	**c**	**e**	**C^w**	**K**	**Fya**	**Fyb**	**Jka**	**Jkb**	**M**	**N**	**S**	**s**

Additional Antigens/Comments: _____

IRL USE ONLY

Peer:_____ Review: _____