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

INDIANA
IMMUNOHEMATOLOGY REFERENCE LABORATORY

Phone (317) 916-5188 x 1
Fax (317) 916-5189

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.

☐ **Check if requesting CONFIRMED units**	☐ **Check if requesting UNCONFIRMED units**

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: ________

Rev Date 09-03-2019