Versiti does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.

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

IMMUNOHEMATOLOGY REFERENCE LAB
Phone 800-245-3117 x6205
Fax (414) 937-6461

Patient/Sample Name	Last		First		MI	
MR #		Accession #		**SSN**	- -	
DOB	/ /	Gender	☐ M ☐ F	Ethnicity	☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other	
Specimen Type	☐ EDTA/ Plasma ☐ Clot tube/Serum ☐ Other__________	Draw Date	/ /			
Fetal Specimen Type	☐ Amniotic Fluid ☐ Cultured Amniocytes ☐ CVS ☐ Cultured CVS ☐ Fetal Blood ☐ Other ___________	Draw Time	Phleb ID			

Special Reporting Requests:	**PO#:**

Medicare

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? **Yes ☐** **No ☐**

If yes, please complete our beneficiary form located at www.versiti.org/medical-professionals/products-services/requisitions and submit with this requisition.

Preliminary Results will be faxed to: ______________________________ Results needed by (Date): __________________

CLINICAL HISTORY: Diagnosis:____ Hgb/Hct: ___________________

Indication for Transfusion:_________________________ Total Number of Pregnancies:________ (including miscarriages and abortions)

Known Antibodies: ____

Prior Transfusions: ☐ Yes ☐ No Patient Status: ☐ Inpatient ☐ Outpatient

Most recent date transfused: ___________________________ # Units Transfused: ______________ ABO/Rh of units: ________

WORK-UP REQUESTED: SEE REVERSE SIDE FOR IMPORTANT SAMPLE REQUIREMENTS

SEROLOGY

PLEASE ENCLOSE A COPY OF YOUR ABO/Rh, DAT, ANTIBODY SCREEN AND PANEL RESULTS

☐ Antibody Identification **(3060)** ☐ Antibody Titration **(3080)** ☐ DAT Negative Workup **(3111)** ☐ Donath Landsteiner

☐ Thermal Amplitude ☐ Other (please specify) **(3112)** _____________________________________

☐ Drug-Dependent RBC Antibody Study **(3110)** – Drug: _____________________________________

Please complete MEDICATION section on back of form (send >500 mg of suspected drug. Do not reconstitute.)

☐ Crossmatch Problem (IRL to crossmatch units) **(3050)** **Patient ID # used for transfusion:** ______________________________

Number of units needed: Leuko-reduced RBC________ ☐ CMV Neg ☐ Irradiate ☐ Other__________________________

PRENATAL (FETAL) GENOTYPING

Maternal blood for MCC must be submitted with fetal sample

Maternal Antibody(ies)____

Paternal Name______________________________ **D.O.B**___________

Paternal blood (recommended) **Paternal Type** (if known)______ ☐ Not Available

Red Cell Genotype:

☐ RHD **(3872)** ☐ M/N **(3864)** ☐ Js(a)/Js(b) **(3858)**

☐ K/k **(3854)** ☐ Fy(a)/Fy(b) **(3860)** ☐ Lu(a)/Lu(b) **(3868)**

☐ C/c **(3850)** ☐ Jk (a)/Jk(b) **(3862)** ☐ Kp(a)/Kp(b) **(3856)**

☐ E/e **(3852)** ☐ S/s **(3866)** ☐ Do(a)/Do(b) **(3870)**

☐ RhD Zygosity (Paternal only) **(3874)**

MOLECULAR

☐ Weak RhD Analysis **(3040)**

☐ Partial RhD Analysis **(3240)**

☐ Red Cell Genotyping Panel (44 Ags) **(3530)**

☐ Red Cell Genotyping STAT Panel (24 Ags) **(3500)**

Comments: ______________________________

____

____

BCW Use Only	
____EDTA ____Clot ____Amnio ____CVS ____Other __________	Opened By _________ Evaluated By ________ Reviewed By ________ Labeled By _________

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All samples must include sample identification clearly marked on **each** specimen container. Proper identification includes full name of individual, date obtained, hospital and/or patient identification number and the identification of the individual obtaining the specimen. Federal regulations mandate that a completed laboratory requisition form accompany each sample. Blood samples must be packaged to comply with requirements of mail or overnight courier service, if used.

Shipping address: Versiti Wisconsin - Immunohematology Reference Laboratory
638 N. 18th Street
Milwaukee, WI 53233
Phone: (414) 937-6205

Recommended tubes for collection -- **Do not use tubes that contain a silicone separator gel:**
Plain red top vacutainers for clotted (serum) samples -- Lavender/Pink top vacutainer with EDTA anticoagulant

SPECIMEN REQUIREMENTS	
SUSPECTED SEROLOGIC PROBLEM	**REQUESTED AMOUNT**
Warm Autoimmune Hemolytic Anemia – IAT Positive with all panel cells tested and a positive DAT (1+ - 4+) *For patients under 20 kg body weight, sample requirements will be adjusted depending on communication with patient's physician.	**No transfusion** within the past 3 months: HGB < 5.0 g/dl: 10 (5ml) EDTA tubes and 3 (7ml) red top tubes HGB ≥ 5.0 g/dl: 6 (5ml) EDTA tubes and 3 (7ml) red top tubes **Transfused** within the past 3 months: 1 (5ml) EDTA tube and 5 (7ml) red top tubes
ABO Antibody Titers	2 (5ml) EDTA tubes or 2 (7ml) red top tubes
Crossmatch Problem Antibody Identification Transfusion Reaction Antibody Confirmation Antibody Titration	All require 1 (5ml) EDTA top tube and 3 (7ml) red top tubes.
DAT Negative Autoimmune Hemolytic Anemia Study	2 (5ml) EDTA tubes and 3 (7ml) red top tubes
Thermal Amplitude or Donath-Landsteiner Test	1 (5ml) EDTA tube and 3 (7ml) red top tubes **prewarmed and maintained at 37°C during clotting and serum separated immediately**
Hemolytic Disease of the Newborn	Child – Cord blood sample (if available) Mother – 1(5ml) EDTA tube and 3 (7ml) red top tubes
Drug-Dependent RBC Antibody Study (complete the medication history listed below)	1 (5ml) EDTA tube, 3 (7ml) red top tubes and **include a sample of each suspected drug**

MOLECULAR TESTS	REQUESTED AMOUNT
Rh D Discrepancy Analysis / Partial D Analysis	1 (5ml) EDTA tube
Red Cell Genotyping Panel (44 Antigens)/ Red Cell Genotyping STAT Panel (24 Antigens)	1 (5ml) EDTA tube
Prenatal Genotyping	**FETAL**: 7-15 mL Amniotic Fluid or 5-10 mg CVS **Backup Culture** (highly recommended)**:** Two (2) T25 flasks Cultured Amniocytes or CVS (2 × 10^6 minimum) **MATERNAL**: 3-5 mL EDTA whole blood for MCC (lavender top). **PATERNAL**: 3-5 mL EDTA whole blood

MEDICATION --- List all medications, prescription and non-prescription, taken in the past 30 days (include: aspirin, anticoagulants, oral contraceptives, or antibiotics)

Medication	Dose	Date Begun	Last Taken

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