Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti.
Client # required

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

ILLINOIS IMMUNOHEMATOLOGY REFERENCE LAB
Phone (630) 264-7832
Fax (630) 892-8648

SPECIAL REQUESTS

INDICATE PRIORITY	☐ **Routine**	**Standard processing with results reported within 3 business days or indicate Date/Time needed:** _____
	☐ **STAT**	**Results will be expedited within 1 business day (M-F)**
	☐ **EMERGENT**	**Immediate Processing of Sample: Notify Laboratory Prior to Sending** ****Additional Fees May Apply**

Fax Preliminary Results to:

PATIENT DEMOGRAPHIC INFORMATION

Patient/Sample Name	Last		First		MI		
MR #		Accession #		ABO/Rh			
DOB	/ /	Gender	☐ M ☐ F	Ethnicity	☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other: _____		
Specimen Type	☐ EDTA/ Plasma ☐ Clot tube/Serum ☐ Other: _____			Draw Date/Time:	/		

TRANSFUSION / SEROLOGIC HISTORY

Diagnosis:		Hgb/Hct:	
Indication for transfusion:		# of Pregnancies (Including miscarriages & abortions):	
Known Antibodies:			
Prior Transfusions: ☐ Yes ☐ No	ABO/Rh of Units:	Has Patient received a transplant?	☐ Yes ☐ No
Most recent transfusion date(s):		# Units Transfused:	

REASON FOR SUBMISSION

Please check or circle the reason(s) for sample submission. Note: Additional testing may be performed as required.
PLEASE ENCLOSE A COPY OF PATIENT MEDICATION LIST AND ANY ABO/RH, DAT, ANTIBODY SCREEN AND PANEL RESULTS

☐ Antibody Identification ☐ Antibody Titration ☐ Positive DAT/Elution ☐ ABO/Rh Discrepancy ☐ Incompatible crossmatch

☐ Suspected HTR investigation ☐ Platelet Crossmatch ☐ HDN Investigation ☐ Other: _____

ADDITIONAL SERVICES (Performed by Versiti Wisconsin)

☐ DAT Negative Workup **(3111)**	☐ Weak RhD Analysis (3040)
☐ Donath Landsteiner	☐ Partial RhD Analysis (3240)
☐ Thermal Amplitude	☐ Red Cell Genotyping Panel (44 Antigens) (3530)
☐ Other (please specify) **(3112)** _____	
☐ Drug-Dependent RBC Antibody Study	

COMPLETE IF UNITS ARE REQUESTED

Number of units needed: _____ ☐ **CMV Seronegative** ☐ **Irradiated** ☐ **Washed** ☐ **HgbS Negative**

Antigen Negative for: _____	☐ Compatibility screened – Patient ID# for tag number (must appear on sample tubes) _____

Versiti Use Only

_____EDTA _____Clot _____Amnio _____CVS _____Other _____	Opened By _____ Evaluated By _____ Reviewed By _____ Labeled By _____

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Client # required

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.

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.

Shipping address for Standard Work-ups:

Versiti Illinois, Inc. – Immunohematology Reference Laboratory
1200 N. Highland Ave
Aurora, IL 60506
Phone: (630) 264-7832

Shipping address for Additional Services:

Versiti Wisconsin, Inc. - 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:** 24mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top) **Transfused within the past 3 months:** 10mL EDTA whole blood (lavender or pink top) AND 30mL clotted whole blood (red top)
Antibody Identification Antibody Titration Incompatible Crossmatch ABORh Discrepancy Suspected HTR HDN Investigation	5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top)
Positive DAT/Elution	10mL EDTA whole blood (lavender or pink top) AND 10mL clotted whole blood (red top)
Platelet Crossmatch	10mL EDTA whole blood (lavender or pink top)
DAT Negative Autoimmune Hemolytic Anemia Study	10mL EDTA whole blood (lavender or pink top) AND 21 mL clotted whole blood (red top)
Thermal Amplitude or Donath-Landsteiner Test	5mL EDTA whole blood AND 21mL clotted whole blood **prewarmed and maintained at 37°C during clotting and serum separated immediately**
Drug-Dependent RBC Antibody Study (complete the medication history listed below)	5mL EDTA whole blood AND 21mL clotted whole blood (red top) and **include a sample of each suspected drug**

MOLECULAR TESTS	REQUESTED AMOUNT
Weak RhD Analysis / Partial RhD Analysis	5mL EDTA whole blood (lavender or pink top)
Red Cell Genotyping Panel (44 Antigens)	5mL EDTA whole blood (lavender or pink top)

MEDICATION --- List all medications, prescription and non-prescription, taken in the past 30 days (include: aspirin, anticoagulants, oral contraceptives, or antibiotics) Please attach a second sheet if the room provided is not sufficient.

Medication	Dose	Date Begun	Last Taken