

Client # required



MICHIGAN IMMUNOHEMATOLOGY REFERENCE LAB
 Phone (616) 233-8583
 Fax (616) 233-8687

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

SPECIAL REQUESTS	
INDICATE PRIORITY	<input type="checkbox"/> Routine Standard processing with results reported within 3 business days or indicate Date/Time needed: _____
	<input type="checkbox"/> STAT Results will be expedited within 1 business day (M-F)
	<input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other: _____
Specimen Type	<input type="checkbox"/> EDTA/ Plasma <input type="checkbox"/> Clot tube/Serum <input type="checkbox"/> Other: _____ Draw Date/Time: _____ / _____

TRANSFUSION / SEROLOGIC HISTORY	
Diagnosis:	Hgb/Hct: _____
Indication for transfusion:	# of Pregnancies (Including miscarriages & abortions): _____
Known Antibodies:	
Prior Transfusions: <input type="checkbox"/> Yes <input type="checkbox"/> No	ABO/Rh of Units: _____ Has Patient received a transplant? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Antibody Identification <input type="checkbox"/> Antibody Titration <input type="checkbox"/> Positive DAT/Elution <input type="checkbox"/> ABO/Rh Discrepancy <input type="checkbox"/> Incompatible crossmatch <input type="checkbox"/> Suspected HTR investigation <input type="checkbox"/> HDN Investigation <input type="checkbox"/> Donath Landsteiner <input type="checkbox"/> Thermal Amplitude <input type="checkbox"/> Drug-Dependent RBC Antibody Study <input type="checkbox"/> Other: _____	

ADDITIONAL SERVICES (Performed by Versiti Wisconsin)	
<input type="checkbox"/> DAT Negative Workup (3111)	<input type="checkbox"/> Weak RhD Analysis (3040)
<input type="checkbox"/> Other (please specify) (3112) _____	<input type="checkbox"/> Partial RhD Analysis (3240)
	<input type="checkbox"/> Red Cell Genotyping Panel (44 Antigens) (3530)

COMPLETE IF UNITS ARE REQUESTED	
Number of units needed: _____	<input type="checkbox"/> CMV Seronegative <input type="checkbox"/> Irradiated <input type="checkbox"/> Washed <input type="checkbox"/> HgbS Negative
Antigen Negative for: _____	<input type="checkbox"/> Compatibility screened – Patient ID# for tag number (must appear on sample tubes) _____

Versiti Use Only		
____ EDTA	____ Clot	Opened By _____
____ Amnio	____ CVS	Evaluated By _____
____ Other _____		Reviewed By _____
		Labeled By _____

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

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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.

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 Michigan, Inc. – Immunohematology Reference Laboratory
 1036 Fuller Avenue Northeast
 Grand Rapids, MI 49501
 Phone: (616) 233-8583

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: 5mL EDTA whole blood (lavender or pink top) AND 30mL clotted whole blood (red top)
Antibody Identification ABORh Discrepancy Antibody Titration Suspected HTR Incompatible Crossmatch 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