Immunohematology Reference Laboratory Requisition

Versiti Illinois: Phone 630-264-7832 | Fax 630-892-8648
Versiti Indiana: Phone 317-916-5188 | Fax 317-916-5189
Versiti Michigan: Phone 616-233-8583 | Fax 616-233-8687
Versiti Wisconsin: Phone 414-937-6205 | Fax 414-937-6461

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

Ordering Institution Information			
Person Completing Requisition:	Provider Name:		
Dept:	Provider Contact (Phone/Email):		
Institution:			Client #:
Address:	City:	State:	Zip Code:
Phone (Lab):	Special Reporting Requests (Fax Number/Email):		

Patient Information			
Last Name:	First Name:		MI:
DOB:	MRN:	Accession #:	
Sample Collection Date: Time:	Sex Assigned at Birth: ☐ Male ☐ Female		Ethnicity:

Patient Clinical History – Fill Out Below or Attach Patient Clinical History			
Patient Status: ☐ Inpatient ☐ Outpatient	Hgb/HCT:	Diagnosis:	
ABO/RH:	Known Antibodies:		
Number of Pregnancies:	Currently Pregnant? ☐ Yes ☐ No If Yes, Weeks Pregnant: _____		
Antibody Therapies: ☐ RhIG ☐ IVIG ☐ Anti-CD38 ☐ Anti-CD47 ☐ Other: _____ Date Last Given: _____			
History of Stem Cell Transplant? ☐ Yes ☐ No	Date:	Patient Prior ABO/Rh:	Donor ABO/Rh:
Prior Transfusions: ☐ Yes ☐ No	# of Units:	ABO/Rh of Units	Date(s) Transfused:

Specimen Type – See Page 2 for Specimen Requirements, DO NOT USE TUBES THAT CONTAIN SILICONE SEPARATOR GEL

☐ EDTA/Whole Blood (Lavender/Pink Top) ☐ Clot/Serum (Red Top) ☐ Other: _____

Priority Requests - Requests for Non-Primary Blood Customers are Performed on a *Routine* Basis

☐ **Routine**	**Results on Serology Testing Report within 3 Business Days (M-F)**	**For All Priorities, Indicate Date and Time of Anticipated Transfusion or Surgery:**
☐ **ASAP**	**Results will be Expedited within 1 Business Day (M-F)**	_____
☐ **STAT**	**Immediate Processing of Sample *NOTIFY LABORATORY PRIOR TO SENDING***	

REQUIRED FOR STAT REQUESTS	Provider Name:	Provider Phone Number:
	☐ **Patient Actively Bleeding** ☐ **Urgent or Impending Surgery (Within 24 Hours)**	☐ **Symptomatic Anemia (Patient Hgb < 7.0 or Cardiac Patient Hgb < 8.0) and Transfusion Imminent** ☐ **Other:** _____

Test Orders – Additional Testing May Be Performed As Required. Attach Patient Results and List Medications on Page 2.

☐ Antibody Identification (3060) ☐ Antibody Titration (3080) ☐ Positive DAT/Elution (3020) ☐ ABO Discrepancy
☐ Crossmatch Problem (3050) ☐ Transfusion Reaction Investigation ☐ HDFN Investigation (3100) ☐ Other: _____

Units Requested – **Compatibility Screen is NOT Intended as Crossmatch of Record, Refer to Your Facility's Policy Prior to Unit Issue**

Units Needed: _____ ☐ Compatibility Screened ☐ Irradiated ☐ CMV Neg ☐ Other: _____

Serology Testing Performed at the Wisconsin Location – Routine Testing Only

☐ DAT Negative Workup (3111) ☐ Thermal Amplitude (3021) ☐ Donath Landsteiner (3011)
☐ Drug-Dependent RBC Antibody Study (3110) – Drug(s): _____

Complete MEDICATION Section on Page 2. For Each Drug, Send Dry Powder Weight of 500mg or More (Not Reconstituted).

Molecular Testing Performed at the Wisconsin Location – Routine Testing Only

☐ Red Cell Genotyping Panel (3530) ☐ Weak RhD Analysis (3040) ☐ Weak RhD Analysis (3040) – Reflex to Partial RhD Analysis (3240), If Indicated
☐ Fya/Fyb (3860) – For Duffy Null Associated Neutropenia ☐ Partial RhD Analysis (3240)

VERSITI USE ONLY: ___ EDTA/Whole Blood ___ Clot/Serum ___ Other: _____ Evaluated By: _____

Shipping Addresses	
Versiti-IL 1200 N. Highland Ave Aurora, IL 60506	**Versiti-IN** 3450 N. Meridian Street Indianapolis, IN 46208
Versiti-MI 1036 Fuller Ave NE Grand Rapids MI 49503	**Versiti-WI** 638 N. 18th Street Milwaukee, WI 53233

Sample Identification

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.

Specimen Requirements – Ship Refrigerated or Room Temperature, DO NOT SEND FROZEN

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 provider.	**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 Antibody Titration Crossmatch Problem ABO/Rh Discrepancy Suspected Transfusion Reaction Antibody Confirmation	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)
DAT Negative Autoimmune Hemolytic Anemia Study	10mL EDTA whole blood (lavender or pink top) AND 21mL 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) Consult with IRL M-F 8am - 4pm at 414-937-6205. **For each suspected drug, dry powder weight of 500mg or more (not reconstituted) must be sent with sample(s).**
Hemolytic Disease of the Fetus and Newborn (HDFN)	Child – Cord blood sample (if available) Mother – 5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top)

MOLECULAR TESTS	REQUESTED AMOUNT	REASON/INDICATION FOR SUBMISSION
Weak RhD Analysis	5mL EDTA whole blood (lavender or pink top)	Used for investigation of RhD discrepancies and determination of RhIG candidacy
Partial RhD Analysis	5mL EDTA whole blood (lavender or pink top)	Used for investigation of anti-D or risk of anti-D alloimmunization in Rh Positive patients
Red Cell Genotyping Panel	5mL EDTA whole blood (lavender or pink top)	

***Prenatal Molecular Tests** - **Use the Prenatal Molecular Requisition Form**

Medication – List All Medications, Prescription and Non-Prescription, Taken in the Past 30 Days (Include: Aspirin, Antibiotics, etc.). Attach Full List of Medication if Needed.

Medication	Dose	Date Begun	Last Taken