Hoxworth BLOOD CENTER
UNIVERSITY OF CINCINNATI

Hoxworth Blood Center Immunohematology Reference Laboratory (IRL)
3130 Highland Avenue, Cincinnati, OH 45267
IRL Phone: 513-558-1547 IRL Fax: 513-558-1533

AABB Accredited Immunohematology Reference Laboratory CLIA ID #: 36D0346846

IRL CONSULTATION REQUEST

- **CALL BEFORE SENDING SAMPLES:** Call the IRL at 513-558-1547 or on weekends, holidays and afterhours call 513-558-1539 and have the IRL Tech On-Call paged. Complete form and Sign on Page 3.

PATIENT INFORMATION: (♦ Mandatory Field)

♦ Facility Name:		Facility Phone Number:
♦ Patient Name:		♦ Date of Birth:
♦ Patient Id#:	Race:	♦ Sample Draw Date:
Clinical Diagnosis:		

TEST REQUEST: (♦ Mandatory Field)

♦ REQUEST LEVEL:	☐ EMERGENT	☐ STAT	☐ ASAP	☐ Today	☐ Routine	Date & Time Needed (for non-STAT requests):

♦ TESTING REQUESTED

☐ **ABO / Rh Typing Discrepancy:** Includes any procedure for problem resolution, including identifying plasma antibodies and RBC antigen typing.
☐ **Complete Testing:** Includes any procedure for problem resolution including ABO/Rh.
☐ **Extensive Workup:** Includes any procedures for problem resolution EXCEPT ABO/Rh.
☐ **Plasma Antibody Identification:** Includes any procedure to identify plasma antibodies, including RBC antigen typing.
☐ **WARM Autoantibody Adsorption Study:** Includes procedures to remove autoantibody from the plasma and identifying underlying alloantibodies, including RBC antigen typing.
☐ **COLD Autoantibody Adsorption Study:** Includes procedures to remove autoantibody from the plasma and identifying underlying alloantibodies, including RBC antigen typing.
☐ **Elution Study:** Includes Direct Antiglobulin Tests (DATs), preparation, and testing of the eluate.
☐ **Patient Antigen Typing - Serological Testing: Specifiy antigen(s):** ____________________
☐ **Patient Antigen Typing: DNA Genotyping/Phenotyping:** ***Call IRL before sample collection.***
☐ **Investigation of Unexpected Positive Crossmatch:** Includes DAT testing on donor unit(s), patient plasma antibody identification, and donor & patient antigen typing as needed.
☐ **Cold Auto-Immune Hemolytic Anemia Workup (CHD & PCH):** Requires special sample collection. Call the IRL before sample collection.
☐ **Suspected Transfusion Reaction Reaction Workup:** ***See the IRL Sample Requirements document for special instructions.***
☐ **Hemolytic Disease of the Newborn Workup:** ***See the IRL Sample Requirements document for special instructions.***
☐ **Drug Induced Hemolytic Anemia Workup:** ***See the IRL Sample Requirements document for special instructions. Call IRL before sample collection.***

PRENATALTESTING REQUESTED

Expected Delivery Date:____________________ **Number of Previous Pregnancies:**____________________
☐ **Prenatal Antibody Identification and Titer:** **Was RhIg Given?** ☐ Yes ☐ No **Date RhIg Given:**______________
☐ **Prenatal Antibody Titer Only: List antibody specificity(ies):** ____________________
☐ **Investigation of Anti-D + Anti-C + Anti-G**

☐ **Other:** ____________________

RBC UNITS NEEDED: (♦ Mandatory Field)

☐ **Call Before Providing Blood**	♦ **Special Unit Requirements?**	☐ None ☐ Irradiated ☐ HgbS Negative
♦ **Number of Units Needed:** __________		☐ Washed ☐ < 5 days old ☐ Freshest Available
☐ Select units using adsorbed plasma		☐ Other:

Antigen Testing Instructions: ☐ Confirmed (IRL performs typing)
☐ Unconfirmed (IRL provides historically negative units, confirmatory antigen typing performed by hospital.
☐ Other:
For UNCONFIRMED units: Is the antisera needed for testing available? ☐ **Yes** ☐ **No**

REFERRING LABORATORY RESULTS (♦ Mandatory Field)

♦ ABO/Rh ________	**♦ Patient Antibody History:**				
Patient Antigen Typing:					
♦ Direct Antiglobulin Test:	Technique Used:	☐ Not Tested	☐ Tube	☐ Gel	☐ Solid Phase / Capture
Results:	Polyspecific AHG ____________	Anti-IgG ____________		Anti-C3 __________	
♦ Antibody Screen:	Technique Used:	☐ Not Tested	☐ Tube	☐ Gel	☐ Solid Phase / Capture
Results:	Immediate Spin Phase:		IgG Phase:		
♦ Current Hgb & Hct:					

Test Results: Additional Information: ____

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TRANSFUSION HISTORY (*Include transfusions received at other hospitals*) (♦ Mandatory Field)

♦ Date of Last RBC Transfusion: ____________ ☐ No Transfusions ☐ Not Available

♦ Transfusion History, Including Those Received At Other Hospitals:

Date	Number of Units	Date	Number of Units
________	____________	________	____________
________	____________	________	____________
________	____________	________	____________

♦ MEDICATIONS: List (or attach a list) ALL medications patient has taken in last 3 months. (♦ Mandatory Field)

☐ **See Attached List** ☐ **Not taking any medications** ☐ **Not Available**

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

♦ REQUEST SUBMITTED BY: (♦ Mandatory Field)

Tech Signature:	Date:

IRL USE ONLY

Case #: ____________ Date Recd: ____________ Time Recd: ____________ Late Charge: ________

Previous Record ____

Computer Records Found In: RLS: Y / N HBCRAR: Y / N

Record Search Performed By: ____________ Date: ____________