South Texas Blood & Tissue Center

"Serving the community for over 30 years"

SPECIAL PROCEDURES LABORATORY
Consultation Request

For QualTex Use Only: Specimen #: _____

History: _____

Fill out this form completely. Detailed history, test results and related data are necessary to facilitate resolution of your problem.

INSTRUCTIONS FOR SUBMITTING BLOOD SAMPLES

NOTE: IMPROPERLY LABELED SAMPLES WILL NOT BE TESTED

1. Collect at least two (2) 7 mL blood samples in EDTA tubes and one (1) 5 mL clot tube. Additional sample may be required for further testing.
2. **Label each sample tube legibly and clearly with the following information:**
   - a). **Patient's first and last name**
   - b). **Social Security # or Medical Record #**
   - c). **Date and time collected**
   - d). **Phlebotomist's initials**
3. Priority of Request: ❑ STAT ❑ ASAP ❑ Routine

REASON FOR CONSULTATION: Mark all that apply

- ❑ ABO Discrepancy Investigation
- ❑ Antibody Indentification
- ❑ Positive DAT Investigation
- ❑ Rh (D) Discrepancy Investigation
- ❑ Incompatible Crossmatch Resolution
- ❑ Transfusion Reaction Investigation (Pre and Post samples are required)
- ❑ Cell Separation
- ❑ Titration Studies
- ❑ Other _____

1. PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____

SS # or MR #: _____ DOB: _____

RACE: _____ ❑ MALE ❑ FEMALE

DIAGNOSIS: _____ PHYSICIAN: _____

As applicable: Number of Pregnancies: _____ Number of Deliveries: _____

2. TRANSFUSION HISTORY: Has the patient received a red cell transfusion in the past three (3) months? (check one) ❑ **NO** ❑ **YES** If Yes, please list details, i.e., date, # of units, type of component, hospital/agency where transfusion took place, etc.

3. MEDICATIONS: Indicate or attach list

ISO REGISTERED FIRM

Main Office: 6211 IH 10 West at First Part Ten Blvd. • San Antonio, Texas 78201 • (210) 731-5555 • 1-800-292-5534 • FAX (210) 731-5505
Victoria Branch: 1109 Sam Houston Drive • Victoria, Texas 77901 • (361) 576-3651 • 1-800-345-4967 • FAX (361) 573-1621

4. **Rh IMMUNE GLOBULIN:** Has patient received Rh Immune Globulin in the last three (3) months?

❑ NO ❑ YES 4a. If Yes, enter date received: _____

4b. Type received: ❑ Rh Immune Globulin ❑ IV IgG ❑ WinRho

5. **SEROLOGICAL DATA / DIFFICULTIES:**
(complete the section(s) that apply and attach copy of work-up if available)

ABO/Rh Type: _____

Direct Antiglobulin Test (DAT)		
Poly	Anti- IgG	Anti- C3b, C3d

Indirect Antiglobulin Test (IAT) *Method used:* ❑ LISS-IAT ❑ PEG-IAT				❑ GEL
Screening Cells	I.S.	37°C	AHG / CC	GEL
I / 1				
II / 2				
3				
Auto				

6. **TRANSFUSION REQUIREMENTS:**

Does patient requires red blood cell products?

❑ NO ❑ YES If yes, indicate number of units: _____

Mark as needed: ❑CMV Neg ❑IRRADIATED ❑SICKLE CELL Neg ❑ Washed ❑Other____

Segments Sent? ❑ NO ❑ YES If yes, indicate unit number and segment number:

7. **ATTENTION:** *The individual whose signature appears below verifies: (1) The information contained on this requisition is accurate; and (2) The samples being submitted are properly labeled AND are the required quantities.*

Submitted by: _____ Date: _____

8. **SEND FINAL REPORT TO:**

Name: _____ Fax #: _____

Facility Name: _____ Tel. #: _____

Address: _____ City: _____ State: _____ Zip: _____

FOR QUALTEX LABORATORIES USE ONLY

Comments: _____

_____

_____

_____

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