QUALTEX LABORATORIES
An affiliate of South Texas Blood & Tissue Center

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**

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: _____

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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