

ATTN: SMC BLOOD BANK REQUEST FOR REFERENCE COMPATIBILITY TESTING/ ANTIBODY IDENTIFICATION

SANFORD MEDICAL CENTER 1305 West 18th St.

Sioux Falls SD 57117-5039 Phone: (605)333-7081 Fax: (605)333-1524

INSTRUCTIONS: Complete information must accompany each specimen. Each specimen <u>must</u> be labeled to meet current AABB Standards, which require two unique identifiers. Label each specimen with name, identifying number (medical record number, Social Security number, and/or Blood Bank Identification number), and the date drawn (all written in ink.) **IMPROPERLY LABELED SPECIMENS WILL NOT BE PROCESSED.**

SPECIMEN REQUIREMENTS: Submit 10-15 mls of clotted blood and 5-7 mls of EDTA whole blood sample.	
	e):Physician:
	City: Phone No.:
TEST REQUESTED: □ Antibody Identification	□ Elution study
☐ ABO and Rh typing	☐ Crossmatch: Number of RBC units requested
☐ DAT and monospecific AHG	☐ Other (specify)
PATIENT INFORMATION:	
Patient's name: (Please print) Last First	Date of Birth:Sex:
Identifying number: Date sample drawn:	
Clinical diagnosis:	
Medications:	
TRANSFUSION HISTORY: No Yes, date of lastquantity OBSTETRICAL HISTORY: Pregnancy No Yes, indicate number and date of last	
Has patient received Rh immune globulin in the past 6 months? ☐ No ☐ Yes, date received	
HISTORY OF PREVIOUS RED CELL ANTIBODY: ☐ No ☐ Yes, specify(ies)	
DESCRIPTION OF REQUESTING FACILITY'S RESULTS:	
Blood type DAT	Auto Control FMH Screen
Red cell antibody screening (circle phase of reaction, results and method used)	
Reaction phase: RT 37C IAT R	Reaction Strength: 1+ 2+ 3+ 4+ micro
Method: saline albumin LISS	PEG Gel
Units crossmatched? Yes Compatible _	Incompatible (Qty)