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 both sides of form and sign at bottom of page 1.**

REQUEST LEVEL: (♦ Mandatory Field)

☐ **STAT**	Critical In-Patient: with order to TRANSFUSE IMMEDIATELY. i.e. OR / ER / ICU patient or actively bleeding patient
☐ **ASAP** **(As Soon As Possible)**	Non-critical In-Patient with order to transfuse or surgery scheduled within 24 hours and Out-Patient same day transfusions. Completion within 24 hours. ♦ Date / Time Blood Needed ____________________________ ☐ **Call Before Staying Late** ☐ Surgery
☐ **ROUTINE**	Patients with no transfusion orders or future date transfusion / surgery. Completion within 1 – 5 days. i.e. Prenatal, Out-Patient future transfusion, Pre-Op testing samples ♦ Date / Time Blood Needed ☐ Surgery

PATIENT INFORMATION: (♦ Mandatory Field)

♦Facility Name		Facility Phone Number
♦Patient Name		♦Date of Birth or Age
♦Patient Id#		♦Current Hgb/Hct — Race
♦Date of Last RBC Transfusion:	♦Number of Prior Pregnancies:	♦Antibody History? ☐ Yes ☐ No Ab Identified:
♦Sample Date:		
Clinical Diagnosis		

TEST REQUEST: ***Complete Test Results, Transfusion History and Medication List on back of form.***
See Page 2 for sample requirements.

☐ **Complete Testing:** IRL staff performs any procedures necessary for problem resolution. Includes determination of patient's ABO/Rh type.
Select Billing Method: ☐ Use Level + Itemized Billing ☐ Use Itemized Billing only.

☐ **Extensive Workup without ABO/Rh type:** IRL staff performs any procedures necessary for problem resolution except ABO/Rh type.

☐ **Suspected Transfusion Reaction**

☐ **Hemolytic Disease of the Newborn Workup**

☐ **Drug Induced Hemolytic Anemia Workup:** *Call IRL before collection of specimens.*

☐ **Cold Auto-Immune Hemolytic Anemia Workup (CHD & PCH):** *Must be scheduled with IRL. Requires special sample collection procedure, call before specimen collection.*

☐ **Prenatal Antibody Identification & Titer:** RhIg Given? ☐ No ☐ Yes Date _____________ **Expected Delivery Date**: ___________

☐ **Prenatal Antibody Repeat Titer(s) Only:** Antibody Specificity(ies): ____

☐ **Serum / Plasma Antibody Identification:** IRL performs any procedures necessary to identify serum/plasma antibody(s). Includes patient RBC antigen typings as needed to resolve / confirm specificity.

☐ **Autoantibody Adsorption Study:** ☐ **Warm Reactive Autoantibody** ☐ **Cold Reactive Autoantibody**
IRL performs procedures necessary to remove autoantibody from serum/plasma and identify any underlying alloantibodies. Includes patient RBC antigen typings as needed to resolve / confirm specificity.

☐ **Elution Study:** Includes Direct Antiglobulin Tests (DATs) and preparation and testing of eluate.

☐ **Investigation of Unexpected Positive Crossmatch:** Includes DAT testing on donor unit(s), patient serum/plasma antibody identification, and donor & patient antigen typings as needed.

☐ **Patient Antigen Typing:** ☐ **Serological Typings**: List ____
☐ **DNA Genotyping/Phenotyping:** *Call IRL before sample collection.*

☐ **Other:** *Call IRL to arrange* ____

RBC UNITS NEEDED (all units are leukocyte reduced)**:** ☐ **Call Before Providing Blood.**

Number of Units? _______________ ☐ Select units using adsorbed plasma	**Special Unit Requirements?** ☐ Irradiated ☐ HgbS [SCKL] Negative ☐ Washed Other:

REQUEST SUBMITTED BY: (♦ Mandatory Field)

♦Tech Signature:	♦Date:

♦REFERRING LABORATORY RESULTS

ABO/Rh _______________ Rh Phenotype ________________ Other Patient Antigen Typings____

Direct Antiglobulin Test	Antibody Screen Reactions	Reagents / Techniques Used for Antibody Detection (Mark all that apply)		
Polyspecific AHG ________	IS ____________________	☐ LISS tube	☐ Albumin tube	☐ MTS Gel Card
Anti-IgG _______________	37C __________________	☐ PEG tube	☐ Saline tube	☐ Solid Phase
Amti-C3 _______________	IAT __________________	☐ Enzyme tube	☐ Other ____	

♦TRANSFUSION HISTORY (Include transfusions 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.

____ ____ ____
____ ____ ____
____ ____ ____
____ ____ ____

SAMPLE REQUIREMENTS

A. **LABELING REQUIREMENTS: *IMPROPERLY LABELED SAMPLES WILL NOT BE TESTED***
   1. All specimens MUST be labeled with the following information:
      a. Patient's First and Last Name
      b. Patient's ID Number
      c. Date Collected
   2. ***Patient data (name and ID number) on tube must be legible and must match data recorded on consultation request form.***

B. **SAMPLE VOLUME:**
   1. **Serum/Plasma Antibody Investigation & Autoantibody Adsorption Study** : Minimum Sample:
      a. If DAT is negative: 20 mL EDTA anticoagulated blood
      b. If DAT is positive:
         i. Hgb greater than 8 gm/dL **or** transfused within last 3 months: 30 mL EDTA anticoagulated blood
         ii. Hgb less than 8 gm/dL **and not** transfused within last 3 months: 40 mL EDTA anticoagulated blood
   2. **ABO / Rh Typing Discrepancy Resolution**: 20 mL EDTA anticoagulated blood
   3. **Suspected Transfusion Reactions**: Send Pre and Post-transfusion specimens and labeled segments from the transfused units. Post-transfusion sample: 20 mL EDTA anticoagulated blood. Pre-transfusion sample: Any clotted or anticoagulated blood samples available labeled with collection date.
   4. **Unexpected Positive Crossmatch** (Negative antibody screen and DAT): 20 mL EDTA anticoagulated blood and 2 labeled segments from incompatible unit.
   5. **Hemolytic Disease of the Newborn (HDN)**: 20 mL EDTA anticoagulated maternal blood and 10mL cord blood. ♦Submit separate consultation forms for infant and mother.
   6. **Elution Study Only** (DAT and eluate antibody identification): 10 mL EDTA anticoagulated blood.
   7. **Prenatal Patient:**
      a. Antibody Identification and Titer: 20 mL EDTA anticoagulated blood.
      b. Repeat Titer (no antibody identification): 7 mL EDTA anticoagulated blood.
   8. **Drug-Induced Hemolytic Anemia Workup:** ♦Call IRL for sample requirements. May need to provide drug.
   9. **Cold Autoimmune Hemolytic Anemia (CHD and PCH):** ♦ Must schedule with IRL. Requires special sample collection and handling procedures.
   10. **Patient Antigen Typing:** For serological typing in a non-transfused patient: 5 - 7 mL EDTA anticoagulated blood. ♦For transfused patients or for RBC DNA genotyping, call the IRL.
   11. For miscellaneous sample requests or when sample volume is a problem, call the IRL for adequate sample volume to be submitted.

Billing

A. **Level Billing:** Single charge that includes routine ABO/Rh typing, limited antibody identification and limited patient antigen typing. The charge level is determined by the number of antibody identification panels performed. Any additional tests/procedures required for workup completion are itemized. *The Level Billing option is only available for Complete Workups.*
   a. Level 1: Includes 1 routine ABO/Rh typing, 1 patient antigen typing and up to 2 antibody identification panels (up to 24 cells).
   b. Level 2: Includes 1 routine ABO/Rh typing, up to 4 patient antigen typings and up to 4 antibody identification panels (up to 48 cells).

B. **Itemized Billing:** All tests / procedures are billed individually.

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: ___________________