

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)

<input type="checkbox"/> STAT	Critical In-Patient: with order to TRANSFUSE IMMEDIATELY. i.e. OR / ER / ICU patient or actively bleeding patient
<input type="checkbox"/> 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 _____ <input type="checkbox"/> Call Before Staying Late <input type="checkbox"/> Surgery
<input type="checkbox"/> 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 _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
◆ Sample Date:		Ab Identified:	
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 _____
- 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? _____	Special Unit Requirements? <input type="checkbox"/> Irradiated <input type="checkbox"/> HgbS [SCKL] Negative <input type="checkbox"/> Washed
<input type="checkbox"/> Select units using adsorbed plasma	Other: _____

REQUEST SUBMITTED BY: (◆ Mandatory Field)

◆ Tech Signature: _____	◆ Date: _____
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◆ 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
Anti-C3 _____ IAT _____ [] Enzyme tube [] Other _____

◆ TRANSFUSION HISTORY (Include transfusions received at other hospitals)

Table with 4 columns: Date, Number of Units, Date, Number of Units. Multiple rows for data entry.

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

Multiple horizontal lines for listing medications.

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 _____

Record Search Performed By: _____ Date: _____