

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 _____ **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? _____	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

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: _____