

Laboratory Testing Request Form

Laboratory

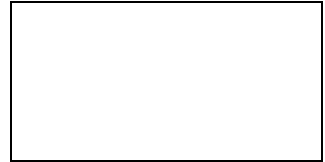
Red Cell Serology
 Blood Service (SA)
 301 Pirie Street
 Adelaide SA 5000
 PH: (08) 8422 1255
 FX: (08) 8112 1342

Storage and Transport Guidelines

Store samples at 2-8°C.
 Pack Samples in a secure container and transport cool/refrigerated as per regulatory requirements.
 Transport time should not exceed 48 hours

Sample Labelling Requirements

Patient samples MUST be clearly labelled with full name, date of collection and either date of birth or MRN.
 Ensure samples and request forms display identical information



Insert Blood Service barcode label

Specimen Details

Client Sample Reference _____		Client Laboratory Number _____	
(UR Number)			
Surname _____		Given Name(s) _____	
DOB _____ / ____ / ____	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Collection Date _____ / ____ / ____		Collection Time (24hr) _____	
Collected By _____			
<input type="checkbox"/> Whole Blood	<input type="checkbox"/> Cord Blood	<input type="checkbox"/> Fresh	
<input type="checkbox"/> Plasma	<input type="checkbox"/> Cadaveric sample	<input type="checkbox"/> Frozen	
<input type="checkbox"/> Serum	<input type="checkbox"/> Other _____	<input type="checkbox"/> Thawed	

Sample collected, labelled, stored and transported in compliance with Blood Service requirements (refer to agreement)

Yes No (Blood Service approval required)

STORAGE COMMENTS/NOTES _____

Test(s) Required

Urgent Yes No

<p><u>Infectious Diseases Screening</u></p> <p><input type="checkbox"/> Anti-HIV I/II</p> <p><input type="checkbox"/> Anti-HTLV I/II</p> <p><input type="checkbox"/> Anti-HCV</p> <p><input type="checkbox"/> HBsAg</p> <p><input type="checkbox"/> Anti-HBs</p> <p><input type="checkbox"/> Anti-HBc</p> <p><input type="checkbox"/> Anti-CMV</p> <p><input type="checkbox"/> BCS (Bacterial Contamination Screening)</p> <p><input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Malaria</p>	<p><u>Red Cell Serology</u></p> <p><input type="checkbox"/> ABO</p> <p><input type="checkbox"/> Rh(D)</p> <p><u>Other – Please specify</u> _____</p>
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Client Details

Client Name & Address for Reports		Invoicing Address	
Name _____	Name _____	Address _____	Address _____
Address _____	Address _____	Phone _____	Phone _____
Phone _____	Phone _____	Fax _____	Fax _____
Fax _____	Fax _____		

Additional Comments

LAB USE ONLY (Initial & Date)

Sample received: _____ / ____ / ____