

Laboratory Testing Request Form

Laboratory

Blood Service-WA
290 Wellington St
Perth WA 6000
PH: (08) 9421 2825
FX: (08) 9421 2841

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 _____ (UR Number) | Client Laboratory 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"/> Plasma | <input type="checkbox"/> Cadaveric sample |
| <input type="checkbox"/> Serum | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Fresh |
| | <input type="checkbox"/> Frozen |
| | <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

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

Client Details

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

Additional Comments

LAB USE ONLY (Initial & Date)

Sample received: _____ / / _____