

Red Cell Reference Laboratory Request - QLD

Red Cell Reference Laboratory

Australian Red Cross Blood Service
 44 Musk Ave (Delivery on Blamey St)
 KELVIN GROVE QLD 4059
 Phone: 07 3838 9493
 Fax: 07 3838 9410

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 labeled with full name, date of collection and either date of birth or MRN.
 Ensure samples and request forms display identical information

The Red Cell Reference Laboratory reserves the right to refuse receipt of samples not adhering to the above requirements

Degree of Urgency: Routine ASAP Urgent (Must phone before sending)

Patient/Donor Details:

Surname _____ Given Name(s): _____
 DOB: ___ / ___ / ____ Sex: M / F Other ID: _____
 Address _____ Collection Date ___ / ___ / ____
 _____ Donor ID: _____
 _____ Donation No _____

Patient/Donor History:

Previous Diagnosis: _____
 Previous Transfusion: Y / N Date Last Transfusion ___ / ___ / ____
 Unit Numbers (If Applicable): _____
 Pregnant now: Y / N Previous Pregnancies Y / N
 Gestation: _____ Due Date: ___ / ___ / ____
 Rh(D) Ig Given: Y / N Last Given: ___ / ___ / ____

<p>Reason for Referral:</p> <p><input type="checkbox"/> Antibody Identification</p> <p><input type="checkbox"/> ABO Investigation</p> <p><input type="checkbox"/> Rh (D) Investigation</p> <p><input type="checkbox"/> Anti-D / anti-c Quantitation</p> <p><input type="checkbox"/> Cord Blood Investigation</p> <p><input type="checkbox"/> Phenotype: _____ (Specify)</p> <p><input type="checkbox"/> Other: _____ (Specify)</p>	<p>Sample Requirements:</p> <p>2x 10mL clotted + 6mL EDTA + incompatible units</p> <p>6mL EDTA</p> <p>6mL EDTA</p> <p>1mL serum or plasma</p> <p>6mL EDTA + maternal sample</p> <p>6mL EDTA</p>
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Your Laboratory Findings: **(Attach all Worksheets):**

ABO/Rh(D) _____ Phenotype: _____ DAT: _____
 Antibody Detected By: Saline RT Low-Ionic IAT CAT Titre: _____
 Saline IAT PEG-IAT Enzyme

Previous Antibody History / Comments _____

<p>Referring Laboratory: _____</p> <p>Contact: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Date Sent: ___ / ___ / ____</p> <p>Signature: _____</p>	<p>ARCBS Use Only:</p>
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