Australian Red Cross BLOOD SERVICE

Red Cell Reference Laboratory Request - NSW

Please address samples to:
Red Cell Reference Laboratory
Australian Red Cross Blood Service
Dock A- Blood In
17 O'Riordan St
ALEXANDRIA NSW 2015
Phone: 02 9234 2189
Fax: 02 9234 2193

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.
On outside of container, please clearly write "store at 2-8°C" and address to "Red Cell Reference Laboratory".

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: ___ / ___ / _____

Reason for Referral:	**Sample Requirements:**
☐ Antibody Identification	5mL EDTA and 10mL clotted blood (Incompatible Segments)
☐ ABO Investigation	5mL anticoagulated blood
☐ Rh (D) Investigation	5mL anticoagulated blood
☐ Phenotype: _____ (Specify)	5mL anticoagulated blood
☐ Anti-D Quantitation	1mL serum or plasma
☐ Anti-c Quantitation	1mL serum or plasma
☐ Other: _____ (Specify)	5mL anticoagulated blood

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 _____
_____

Referring Laboratory: _____
Contact: _____
Address: _____
_____
Phone: _____
Fax: _____
Date Sent: ___ / ___ / _____
Signature: _____

ARCBS Use Only: