Bloodworks Labs
LABORATORY SERVICES

REQUEST FOR TESTING

Immunohematology Reference Laboratory (IRL)
921 Terry Ave. | Seattle, WA 98104
Phone 206-689-6534 | **Fax** 206-689-8357
Laboratory Staffed for Questions 24/7

Specimen Number

Order Number

For current test descriptions and CPT codes visit https://www.bloodworksnw.org/labs/tests

BW Tech ID _____

TIME RECEIVED

TESTING PROFILES – May include one or more of the individual tests given below.

- ☐ Antibody Identification
- ☐ Hemolysis evaluation
- ☐ Suspected delayed hemolytic transfusion reaction
- ☐ Prenatal Antibody Identification (includes antibody titration, if indicated)
- ☐ Long term marrow transplant (HSCT) recipient follow-up
- ☐ Resolution of ABO discrepancy
- ☐ Polyagglutination (includes lectin panel, if indicated)
- ☐ Other (please specify)_____

INDIVIDUAL TESTS – If Profile has been checked above, do NOT check test below.

3103-03	☐ ABO & Rh (D antigen typing)	3139-00	☐ Donath-Landsteiner Test for PCH
3103-03	☐ Solid Organ Donor ABO & Rh (A1 lectin if group A) RF11	3140-00	☐ Thermal Amplitude
3105-00	☐ % ABO for HSCT		
3104-02	☐ Indirect Antiglobulin Test (antibody screen)	3115-00	☐ Anti-A Titer for HSCT
3125-02/01	☐ Direct Antiglobulin Test (polyspecific and monospecific)	3115-00	☐ Anti-B Titer for HSCT
3129-00	☐ Elution	3115-00	☐ ABO Incompatible Heart Transplant Titer (☐anti-A or ☐anti-B)
3117-00/3118-00	☐ Sickle Cell Phenotype (Rh & K)	3115-00	☐ ABO Incompatible Liver Transplant Titer (☐anti-A or ☐anti-B)
3117-00	☐ Rh Phenotype (D, C, E, c and e antigen typing)	3115-00	☐ Kidney UNOS Protocol Titer (anti-A or anti-B)
3136-00	☐ Extended Patient Phenotype (7 or more antigens)	3115-00	☐ Antibody Titer (other than anti-A or anti-B)
3118-00	☐ Single Antigen Phenotype		Specify antibody: _____
	Specify antigen: _____		

The above tests should be performed STAT* ☐ Yes

The above test should be run outside of normal business hours ☐ Yes (*Note, After Hours Surcharge will incur (3141-00))

GENOMICS TESTS (If genomics testing is required please check a box below)

3117-08	☐ ABO Genotyping	3117-04	☐ Red Cell Genotyping for Multiple Blood Groups
			Sickle Cell Disease Yes ☐ No ☐

Reason for DNA Analysis:_____

**Note: For additional genomics testing refer to our website above under Genomics Laboratory*

PLEASE PRINT. Submit separate request and separate blood sample per laboratory.
NOTE: Information in RED must be completed.

Sample Drawn: DATE ____ / ____ / ____ TIME _____ am/pm

Sample Drawn By:

X _____ */X* _____
Person drawing blood and reviewing patient ID — *2nd person reviewing patient ID (If Required by facility policy)*

Specimen/Accession No.: _____

Physician or Authorized Person Order Test _____

Diagnosis/Purpose of Testing: _____

History / Comments / Special Instructions: _____

_____

_____

Form Completed By: _____

Name must match EXACTLY name on sample label.

Name on Sample *LAST*	*FIRST*	*MIDDLE*
Hospital Identification Number		
Hospital/Institution		
Social Security Number	*Sex (M/F)*	*Date of Birth (mm/dd/yr)*

Contact Person: _____
Name *Number*

INCLUDE PHONE NUMBER OR FAX NUMBER TO REPORT RESULTS AS SOON AS AVAILABLE OR FOR STAT TESTING

If results are needed as soon as available, PHONE ☐ or FAX ☐

_____ at (____) _____
Name *Number*

SEND REPORT TO:

Name _____

Street _____

City, State, Zip _____

SEND BILL TO (if different than above):

Name_____

Street _____

City, State, Zip _____

Immunohematology Reference Laboratory (IRL)

Instructions:

1. **Ensure sample is of appropriate type, labeled correctly and the required volume of blood is provided**. **Do not use tubes that contain a silicone separator gel. Additional information on sample requirements, CPT codes, test description, scheduling and reporting can be found at https://www.bloodworksnw.org/lab/tests**

Sample Requirements:

Test	Requested Amount
Antibody Identification Prenatal Antibody Identification (titration) ABO antibody Titers	2 full 7 ml EDTA tubes OR 2 10 ml clotted sample. *see note below for minimum sample requirements
HSCT Long term Follow-up Suspected Delayed Hemolytic Transfusion Reaction Hemolysis Evaluation	2 full 7 ml EDTA tubes *see note below for minimum sample requirements
NOTE: Minimum sample requirement for above tests: One full 7 ml EDTA sample as the minimum amount. Patients 1 - 5 years old: One full 3 ml EDTA sample minimum. Patients ≤1 year old: Two full 0.5 ml EDTA microtainers (1.0 ml total) of peripheral blood is the minimum amount.	
Donath-Landsteiner Test	10 ml clotted sample drawn and maintained at 37°C until serum is separated from clot.
Thermal Amplitude Test	10 ml clotted or 7 ml EDTA sample maintained at 37°C until serum/plasma is separated
ABO Genotyping Red Cell Genotyping for Multiple Blood Groups	7ml EDTA tubes

Contact IRL for sample requirements for any special testing not listed above.

Sample Labeling: All samples must be properly labeled and information must agree with the identification on the RFT.

- The sample requires two patient unique identifiers. If a sample is identified by name, there must be a numeric identifier which may include hospital number or other coded identifier. A birthdate is not acceptable in this circumstance.
- A draw date should be on the sample.

When RBCs are to be crossmatched: Samples must additionally include: full name of patient, date and time obtained, hospital and/or patient identification number and the identification of the individual obtaining the sample**.** Submit a Request for Blood and Blood Components form. Also notify the laboratory for additional sample requirements.

2. Complete the IRL Request for Testing form (RFT); it must contain all of the information that is printed in red: draw date/time, physician or authorized person ordering test, to whom to send the report. Identifying a contact person is required to facilitate timely resolution of discrepancies and questions.

3. Complete and send the Immunohematology Consultation Request Form. Include copies of serological evaluations worksheets.

4. Additional samples: If patient has been transfused within the last 30 days, and submitting for antibody identification, send pre- and post-transfusion samples.

5. Notification and Transport: Notify the laboratory of shipping arrangements by phone (206-689-6534). All samples must be sent to Bloodworks Northwest in a sealed, leak-proof container marked with a biohazard sticker to comply with OSHA safety standards. Ship at ambient temperature unless instructed otherwise.

Tests that may be performed in Profiles:

Antibody Identification	
Red cell panel	3126-00
Direct Antiglobulin Test-Polyspecific	3125-02
Direct Antiglobulin Test-Monospecific	3125-01
Elution	3129-00
Extended Patient Phenotype	3136-00
Rh & K Phenotype	3117-00 3118-00
Red cell separation for phenotyping	3131-00
Auto/allo adsorption	3127-00 3128-00
Chemical treatment of Red Cells Enzyme Treatment of Red Cells Chemical Treatment of Serum	3132-00 3133-00 3134-00
Neutralization	3130-00
Red cell antibody Titrations	3115-00
Note: Reflex to red cell genomics testing if indicated	

Prenatal Antibody Identification	
Red cell panel	3126-00
Direct Antiglobulin Test-Polyspecific	3125-02
Direct Antiglobulin Test-Monospecific	3125-01
Elution	3129-00
Extended Patient Phenotype	3136-00
Rh & K Phenotype	3117-00 3118-00
Red cell separate for phenotyping	3131-00
Auto/allo adsorption	3127-00 3128-00
Chemical treatment of Red Cells Enzyme treatment of Red Cells Chemical Treatment of Serum	3132-00 3133-00 3134-00
Neutralization	3130-00
Red cell antibody Titrations	3115-00
Note: Reflex to red cell genomics testing if indicated	

Hemolysis evaluation	
Red cell panel	3126-00
Direct Antiglobulin Test-Polyspecific	3125-02
Direct Antiglobulin Test-Monospecific	3125-01
Indirect Antiglobulin Test -Antibody screen	3104-02
Elution	3129-00
Positive antibody screen reflex to Antibody Identification as indicated	
Polyagglutination	
Minor crossmatch with adult and cord sera	3137-01
Reflex to lectin panel if indicated	3137-02

Suspected delayed hemolytic transfusion reaction	
Direct Antiglobulin Test-Polyspecific	3125-02
Direct Antiglobulin Test-Monospecific	3125-01
Elution	3129-00
Red Cell Panel	3126-00
AHG crossmatch of implicated RBCs unit Positive AHG Crossmatch reflex to Antibody Identification as indicated	3015-02

Long term marrow transplant (HSCT) recipient follow-up	
Direct Antiglobulin Test-Polyspecific	3125-02
Direct Antiglobulin Test-Monospecific	3125-01
ABO/Rh typing	3103-03
%ABO	3105-00
Indirect Antiglobulin Test-antibody screen	3104-02
Anti-A/Anti-B Titrations	3115-00
Red cell panel Positive antibody screen reflex to Antibody Identification as indicated	3126-00

Resolution of ABO discrepancy	
Direct Antiglobulin Test-Polyspecific	3125-02
Direct Antiglobulin Test-Monospecific	3125-01
Extended Patient Phenotype	3136-00
RBC Phenotype- Single antigen	3118-00
Chemical treatment of Red Cells Chemical treatment of Serum	3132-00 3134-00
Red cell panel	3126-00
Rh & K Phenotype	3117-00 3118-00