Bloodworks Labs
LABORATORY SERVICES

REQUEST FOR TESTING

Genomics Testing Laboratory (for RBC genotyping)

921 Terry Ave. | Seattle, WA 98104
Phone 206-689-6269 | **Fax** 206-689-8378
Laboratory staffed for Questions 8:00am – 4:30pm Monday-Friday

Code		Routine Tests	Test Coverage & Information
3117-01	☐	Red Cell Genotyping for Single Blood Group Specify antigen: ____________________	Example: RHC (C/c); RHE (E/e); Kell (K/k), Kidd (Jk^a/Jk^b); Duffy (Fy^a/Fy^b; GATA mutation); Dombrock (Do^a/Do^b), etc. *Note: if testing is requested for fetal genotype, please complete maternal information section below.*
3117-03	☐	Red Cell Genotyping for MNS Blood Group	M/N; S/s/U (including P2 & NY silencing mutations)
3117-04	☐	Red Cell Genotyping for Multiple Blood Groups Sickle Cell Disease? Yes ☐ No ☐	C/c; E/e; K/k; Js^a/Js^b; Kp^a/Kp^b; Fy^a/Fy^b ; (GATA mutation); Fy^x; Jk^a/Jk^b; M/N; S/s/U (silencing mutations); Lu^a/Lu^b; Do^a/Do^b; Hy+/Hy-; Jo^a; LW^a/LW^b; Di^a/Di^b; Co^a/Co^b; Sc1/Sc2
3117-05	☐	Red Cell Genotyping for RHD & RHCE (includes RHD Zygosity)	D (including zygosity); C/c; E/e. This testing will *not* detect variant alleles. *Note: if testing is requested for paternal zygosity, complete the maternal information section below.*
3117-07	☐	RH Evaluation Serology attached? Yes ☐ No ☐	Genetic sequencing of RHD and RHCE genes. This testing is for the detection of possible variant RHD and/or RHCE alleles.
3117-09	☐	Red Cell Genotyping for Weak D types 1, 2, & 3 Serology attached? Yes ☐ No ☐	Weak D types 1, 2, & 3 only (no RHCE or other RHD variants). *Note: if patient is currently pregnant, please complete maternal information section below*
3117-08	☐	Red Cell Genotyping for ABO	Genetic sequencing of the ABO gene.
3117-06	☐	Red Cell Blood Group Sequencing Specify gene: ____________________	Genetic sequencing of specified Red Cell Blood Group. *Note: prior authorization required, please contact the laboratory.*

Clinical Information (this section MUST be completed)

RBC transfusions within the last 3 months? Yes ☐ No ☐

If so, how many: ______________________

Date of last transfusion: ________________

Red Blood Cell Antibodies? Yes ☐ No ☐

Antibody Specificity: ___________________

Received Stem Cell Transplant? Yes ☐ No ☐

Date: ____________________ Allo ☐ Auto ☐

Reason for DNA Analysis:____

For paternal zygosity, fetal, or maternal weak D testing- please provide maternal information below:

Name of maternal patient:

LAST: _________________________ FIRST: ___________________

Received Rh Immunoglobulin? Yes ☐ No ☐

Antibody specificity: _______________

Antibody titer: ____________________ Date: __________________

If pregnant, gestational age / EDD: ___________________________

G________ P________

Ethnicity of patient: (check all that apply) ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ Other

Specimen Information: Fill in ALL Fields Below

Collection Date: _______/_______/_______ Time: __________ ☐ am ☐ pm

Specimen/Accession #: ____________________________________

Physician or Authorized Provider Ordering Test:

FIRST: ____________________________ LAST: ____________________________

Specimen Identification (Name on Sample)

LAST	
FIRST	*MIDDLE*
Hospital Identification Number (MRN)	
Hospital / Institution	
Date of Birth	*Sex (M/F)*

Drawn by: ____

ICD10 Code: ____

Contact Person: ___________________ ___________________
Name Phone Number

Send Report To:

Institution: ____

Fax Number: ____

Street: _________________________ City, State, Zip: ______________________

Bill To: (unless indicated otherwise, the submitting institution will be billed)
Note: BWNW bills to institutions- not to 3rd party payers

Institution: ____

Street: ___________________________ *City, State, Zip:* ______________________

For specimen and shipping requirements and current test descriptions with CPT codes visit our website at https://www.bloodworksnw.org

All samples must be properly labeled and the information must agree with the identification on the request for testing. A specimen identified by a name must also provide a numeric identifier which may include hospital number, SSN, or other coded identifier. A draw date must be on the specimen and/or request for testing form to be acceptable. All specimens 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 temperatures.**