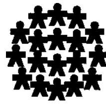
TO REORDER FORMS CALL **PSBC (206) 292-6559**

REQUEST FOR TESTING RED CELL REFERENCE LABORATORY



Puget Sound Blood Center
921 Terry Avenue
Seattle, WA 98104-1256

Lab Tech	PSBC ID / CL #	Time Received

See back of this order form for sample requirements. Current test descriptions and CPT codes may be viewed at psbc.org/medical *Shaded areas for PSBC use only.*

RED CELL REFERENCE LABORATORY (206) 292-6525 Laboratory Staffed for Questions and Results Daily, 24 Hrs./Day
SAMPLE DRAWN FOR THIS LAB MUST MEET THE SAME REQUIREMENT AS SAMPLE DRAWN FOR BLOOD REQUEST.

TESTING PROFILES – with defined individual tests

- 3103-00/3104-00 ☐ Prenatal profile
- 3102-00 ☐ Abbreviated postnatal profile (for Mother or Baby)
- 3103-00/3104-00 ☐ Extended post-natal profile (for Mother)
- 3103-00/3125-00 ☐ Extended post-natal profile (for Baby)
- 3102-00 ☐ Pregnancy follow-up (Rh only)

Antepartum RhIg issued? ☐ Yes (date given) ____________ ☐ No

Mother's name if baby sample ____________

Delivery date (known or estimated) ____________

- 3103-00/3104-00 ☐ Potential Donor Profile
- 3103-00/3104-00 ☐ Transplant Recipient Profile

TESTING PROFILES – may include one or more of the individual tests given below. Billing confirmation of tests performed will be sent after completion of testing.

- ☐ Antibody Identification
- ☐ Hemolysis evaluation
- ☐ Suspected delayed hemolytic transfusion reaction
- ☐ Prenatal Antibody Identification (includes antibody titration, if indicated)
- ☐ Provision of compatible rbc units*
- ☐ Longterm marrow transplant (BMT) recipient followup
- ☐ ABO minor mismatch BMT recipient evaluation
- ☐ Resolution of ABO discrepancy
- ☐ Other ____________
- ☐ Provision of antigen negative rbc units*

*submit "Request for Blood" to identify number of units and processes required

INDIVIDUAL TESTS

Code	Test
3101-00	☐ ABO
3102-00	☐ Rh (D antigen typing)
3103-00	☐ ABO & Rh (D antigen typing)
3104-00	☐ Indirect Antiglobulin Test (antibody screen)
3125-00	☐ Direct Antiglobulin Test
3117-00	☐ Rh phenotype (D, C, E, c antigen typing (e if indicated))
3118-00	☐ Single Antigen Phenotype Specify antigen
3136-00	☐ Extended phenotype (7 or more antigens)
3145-00	☐ Fetal Bleed Screen
3146-00	☐ Kleihauer-Betke Stain
3126-00	☐ Red Cell Antibody Panel (per panel)
3127-00	☐ Autoabsorption
3128-00	☐ Alloadsorption
3129-00	☐ Elution
3130-00	☐ Neutralization
3119-00	☐ Screening of antigen-negative rbc units, per unit
3120-00	☐ Screening of compatible rbc units, per unit
3121-00	☐ Immunohematology sample processing
3131-00	☐ Red Cell Separation for Phenotyping
3105-00	☐ % ABO
3115-00	☐ Antibody Titer (other than anti-A or anti-B)
3115-00	☐ Anti-A titer
3115-00	☐ Anti-B titer ____________
3137-00	☐ Lectin Panel (T activation of rbcs)
3138-00	☐ Cardioplegia test
3139-00	☐ Donath-Landsteiner
3140-00	☐ Thermal Amplitude
3142-00	☐ Ham's Test
3132-00	☐ Chemical Treatment of Red Cells
3133-00	☐ Enzyme Treatment of Red Cells
3134-00	☐ Chemical Treatment of Serum
3141-00	☐ Immunohematology After Hours Surcharge
3116-00	☐ Immunohematology Stat Fee

SAMPLE ONLY

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 ____________

Specimen/Accession No.: ____________

Physician or Authorized Person Ordering Test ____________

Diagnosis/Purpose of Testing: ____________

History / Comments / Special Instructions: ____________

Form Completed By: ____________

Physician: ____________

Name must match EXACTLY name on sample label.

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

Contact Person: ____________ Name ____________ Number

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 ____________

If sample is from other than patient, complete the following:
Patient Name: ____________
Family Member. Relationship: ____________

	Central	Bellevue	Renton	University District
CLIA Numbers:	Central - 50D0661429	Bellevue - 50D0873462	Renton - 50D0869979	University District - 50D0940281
Washington Medical Test Site Numbers:	Central - MTS - 0303	Bellevue - MTS - 1460	Renton - MTS - 1459	University District - MTS - 3307

RED CELL REFERENCE LABORATORY

Completion of the Request for Testing (RFT):
In addition to the specimen identification, the RFT must contain all the information that is printed in red on the RFT: draw date/ time, physician or authorized person ordering test, to whom to send the report, and if a donor, the patient name for whom the donor is donating. Identifying a contact person is highly encouraged to facilitate timely resolution of discrepancies and questions. Other information on the RFT is optional.

Please submit RCRL History if not a local hospital (King County).

Samples – Samples drawn for this laboratory MUST meet the same requirements as samples drawn for a blood request. Sample requirements for some tests are given below; please call the laboratory for samples required for other tests (206-292-6534). Complete information on sample requirements, CPT codes, and test description, scheduling and reporting can be found at http://www.PSBC.org/medical/labs/redcell/. Samples containing silica gel should not be submitted for testing.

If patient has been transfused within the last 30 days, send pre- and post-transfusion samples.

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

- If a specimen is identified by name, there must also be a numeric identifier which may include Hospital number, SS#, birth date, or other coded identifier.
- If only a numeric identifier is used (with no name), the number must be a Hospital number, SS#, or coded identifier. A birth date is not acceptable in this circumstance.
- A draw date should be on the sample but the sample will still be accepted if the draw information is on the RFT.

Transporting Samples: Please notify the laboratory of shipping arrangements by phone (206-292-6534) or Fax (206-343-1778). All samples must be sent to the Blood Center in a sealed, leak-proof container marked with a biohazard sticker to comply with OSHA safety standards. Ship at ambient temperature unless instructed otherwise.

SAMPLE ONLY

Sample Requirements:

Test	Sample Type	Minimum Amount
Abbreviated Postnatal profile – Mother Baby	EDTA	7ml 1 - 2 microtainer
ABO or ABO & Rh	EDTA	7 ml
Antibody Titer	EDTA	7 ml
Antibody Identification	Clotted and EDTA	20 ml EDTA 10 ml Clotted
Direct Antiglobulin Test	EDTA	7 ml
Extended Postnatal Profile – Baby	Cord Blood (prefer EDTA) or Peripheral Blood (prefer EDTA)	7 ml 1 - 2 microtainer
Extended Postnatal Profile – Mother	EDTA	7 ml
Fetal Bleed Screen or Kleihauer – Betke Stain	EDTA	7 ml
Indirect Antiglobulin Test (Antibody Screen)	EDTA	7 ml
Potential Donor Profile	EDTA	7 ml
Pregnancy Follow-up	EDTA	7 ml
Prenatal Profile	EDTA	7 ml
Red Cell Antigen Phenotyping	EDTA	7 ml
Rh Type	EDTA	7 ml
Transplant Recipient Profile	EDTA	7 ml