

REQUEST FOR BLOOD BANK PROBLEM CONSULTATION

Call Alomere Health Blood Bank 320-762-6087
111 17th Ave East, Alexandria, MN 56308

SAMPLE REQUIREMENTS: ABID: Two full EDTA tubes (do not separate cells and plasma)
Fetal Maternal Screen: One EDTA tube
Eluate: One EDTA tube

PATIENT INFORMATION:

Name: _____

MRN: _____ Birthdate: _____ Sex: _____

Date Sample Collected _____

PATIENT HISTORY:

Has patient been transfused before? ____ When/Where? _____

RhIG given? ____ When? _____ Number of pregnancies? _____

Antibody history? _____

HOW URGENT IS THIS PATIENT'S NEED FOR TRANSFUSION? _____

CONTACT INFORMATION: _____

CURRENT LABORATORY DATA:

ABO/Rh _____ DAT _____

	IS	37C	Gel/AHG	CC
SC I				
SC II				
SC III				

NATURE OF REQUEST:

____ Antibody Identification

____ Antigen type segments provided by client

____ Provide antigen negative packed cells

_____ # of units

____ Crossmatch units for compatibility

_____ # of units

____ Eluate

____ Fetal Maternal Screen

____ Other (please explain)



Place Antibody ID sticker here

Wellsky Specimen Batch Transfer # (if applicable): _____