

**ANTIBODY REFERRAL FORM**  
**Methodist Hospital/Children's Hospital**  
**BLOOD BANK DEPARTMENT**  
**8303 Dodge Street**  
**Omaha, NE 68114**  
**(402) 354-4562 (Blood Bank)**

**COLLECTION AND SUBMISSION OF SPECIMEN**

1. Obtain sample and label it according to the instructions to follow:

Sample Type:

1-2 7 ml EDTA tubes (freshly drawn <24 hours old)

Do not submit samples collected in serum separator tubes

For transfusion reaction workup, include donor segments, patient's pre and post-transfusion specimens.

For Hemolytic Disease of the Newborn Investigation, collect a 7 ml EDTA tube from mother and an EDTA tube collected from baby.

Sample Label Must Include:

Patient first and last name

Patient ID number

Date time collected, initials of person drawing specimen

Note: Improperly labeled samples will not be tested

2. If the need for blood is urgent, send unit segments for antigen typing. Alternately, antigen negative blood can be requested from the American Red Cross after antibody(ies) have been identified.
3. Complete this form and contact the Blood Bank at the phone number listed above. Give them the estimated date and time of specimen arrival.

DATE & TIME CALLED: \_\_\_\_\_ PERSON CONTACTED \_\_\_\_\_

**SUBMITTING FACILITY INFORMATION**

Facility Name: \_\_\_\_\_ Request Date: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Phone: \_\_\_\_\_ Facility Fax Number: \_\_\_\_\_

Requesting Physician: \_\_\_\_\_

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
Specimen Date: \_\_\_\_\_ ABO/Rh \_\_\_\_\_ Hgb/Hct \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Medications \_\_\_\_\_  
Transfusion History: No Record \_\_\_\_\_  
                          Within last 3 months: NO \_\_\_\_\_ YES \_\_\_\_\_ Dates/Products: \_\_\_\_\_  
                          Prior to last 3 months: NO \_\_\_\_\_ YES \_\_\_\_\_ Dates/Products: \_\_\_\_\_  
Pregnancy History: Number: \_\_\_\_\_ Currently Pregnant? NO \_\_\_\_\_ YES \_\_\_\_\_  
                          Recently received RhIG: NO \_\_\_\_\_ YES \_\_\_\_\_ Date Given: \_\_\_\_\_  
Known RBC Antibody(ies): \_\_\_\_\_

**TEST REQUEST:**

Routine \_\_\_\_\_ Patient not waiting, transfuse when available  
ASAP \_\_\_\_\_ Patient waiting, transfusion needed as soon as possible  
STAT \_\_\_\_\_ Patient actively bleeding/or scheduled for surgery on \_\_\_\_\_

**SUMMARY OF ANTIBODY TESTING RESULTS:**

Tube _____		IS	37C	AHG
	I	_____	_____	_____
	II	_____	_____	_____
	III	_____	_____	_____

Gel _____		AHG
	I	_____
	II	_____
	III	_____

If gel technology performed, send sealed gel card or Xerox copy of gel card.

Crossmatch Results:

#Compatible Donors \_\_\_\_\_  
# Incompatible Donors \_\_\_\_\_

DAT (or Auto Control): Positive: \_\_\_\_\_  
Negative: \_\_\_\_\_