LOGAN HEALTH MEDICAL CENTER LABORATORY
TRANSFUSION MEDICINE - IMMUNOHEMATOLOGY CONSULTATION REQUEST FORM

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	SEX:
			☐MALE ☐FEMALE
DATE OF BIRTH:			
PHYSICIAN:			
BILL:			
☐ Client:_____			
☐ Medicaid: State through which benefits are received: _____			
☐ Other: _____			

SPECIMEN COLLECTION:		
DATE:	**TIME:**	**COLLECTOR MNEMONICS (INITIALS):**
☐ STAT ☐ ASAP	☐ CALL RESULTS TO THIS NUMBER:	
COPY TO:		
SPECIAL INSTRUCTIONS:		

*****REQUIRED INFORMATION – MUST FILL OUT FOR TESTING TO BE COMPLETED*****

☐ Antibody ID

☐ Antigen Typing: # of unit segments being sent: _____

☐ Provision of Antigen Negative Blood: # of units needed: _____

☐ Direct Antiglobulin Test (DAT) Workup List medications: _____

☐ Other: _____

*****Include copies of all screening results including completed antigram.*****

Transfusion History (Blood Component & Date Transfused): _____

_____

Previously Identified Antibodies: _____

Patient Scheduled for Surgery? ☐ YES, Date of Surgery: _____ ☐ NO

Pregnancy History: _____

_____

Prenatal Patient? ☐ YES ☐ NO

RhIgG (RhoGAM) Administered? ☐ YES, Date of RhIgG: _____ ☐ NO