THE BLOOD CONNECTION
1099 Bracken Road, Piedmont, SC 29673

REFERENCE LABORATORY CONSULTATION FORM: 2505PDFd06

Complete Form as Completely as Possible

*Requesting Hospital			
*Patient Name (first and last)		*SS# or Hospital ID#	
Male ☐ Female ☐	*Date of Birth	*Ordering Physician	*Date and Time Ordered
*Status STAT ☐ 8 hours ASAP ☐ 24 hours Routine ☐ 1- 2 days		Diagnosis	
Transfusion History		Previous Pregnancies (if applicable)	
Known Previous Antibodies		ABO/Rh (if known)	
Medications			
*Form Completed by:			
☐ Phone results to ( )	☐ Fax results to ( )	☐ Send Results to:	

*This is a required field.

Instructions:

1. Tubes and / or forms which lack the required information, are inaccurate, or are illegible will not be accepted. NOTE: Tubes which contain serum separators are not acceptable.
2. **Contact TBC before sending samples**: 864-751-3015 or 864-751-3017.
3. **Sample Requirements**:
   Red Cell Antibody ID Testing: 1 plain red top and 4 EDTA tubes. Acceptable for 72 hours.
   Platelet Crossmatching: 1-2 EDTA tubes. Acceptable for 72 hours.
4. **Sample Labeling:** Label the tubes with the following information: Patient name, SS number or Hospital ID number, Date and time of collection, and phlebotomist identification.
5. **Attach a copy of any red cell testing results which have previously been performed.**

Reason For Request: Red Cell Antibody ID

☐ ABO/Rh Type ☐ Antibody Screen ☐ Antibody ID ☐ Antigen Typing ☐ Complex Workup
☐ Type and Crossmatch # of units _____ Date/Time Units Needed _____
Special Orders (leukoreduced, irradiated, CMV negative etc.)_____
☐ Other _____

Reason For Request: Platelet Crossmatching

☐ Platelet Crosssmatch # of units _____ Date /Time Units Needed _____
Special Orders (leukoreduced, irradiated, CMV negative etc.)_____

TBC Use Only	
Sample Received by:	Date/Time Received:
Sample and Form: (select one) Acceptable Unacceptable	Tech Code:
Description of non-conforming information:	
Person Notified/Date:	

Attach form to compatibility testing records if applicable and route to Director of Technical Services or designee for review.

Reviewed by_____ Date_____