IMMUNOHEMATOLOGY REFERENCE LABORATORY

CONSULTATION REQUEST

QUALTEX LABORATORIES
An affiliate of South Texas Blood & Tissue Center

For QualTex Use Only:	For QualTex Use Only:
History: _____	Place Specimen Label Here
Order/Ship ID:_____/_____	

SAMPLE REQUIREMENTS

NOTE: IMPROPERLY LABELED SAMPLES WILL NOT BE TESTED

1. At least two (2) 7 mL EDTA blood samples
   Additional sample may be required for further testing.
2. Label each sample tube legibly and clearly with the following information (must match EXACTLY):
   - Patient's first and last name
   - Social Security # or Medical Record #
   - Date and time collected
   - Phlebotomist's initials

PATIENT INFORMATION

(Must match tube exactly)

LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME: _____

SS # or MR #: _____

DOB: _____ RACE: _____

❑ MALE ❑ FEMALE DIAGNOSIS: _____

ORDERING PHYSICIAN: _____

SAMPLE INFORMATION

Phlebotomist Name (Print): _____

Sample Collected: Date: _____ Time: _____

PRIORITY OF REQUEST

❑ STAT (Fee applies) ❑ ASAP ❑ Routine

(Does not include Genotype)

FACILITY INFORMATION

Name: _____

Address: _____

Phone #_____

Fax #_____

REQUESTED TESTING

❑ ABO/Rh(D) Typing ❑ Antigen Testing (Phenotype)
❑ Antibody Screen ❑ Antibody Identification
❑ Titration Studies ❑ Cell Separation
❑ Adsorption Studies ❑ Direct Antiglobulin Test (DAT)
❑ Positive DAT Investigation/Elution Only
❑ ABO/Rh(D) Discrepancy Investigation
❑ Incompatible Crossmatch Resolution
❑ Transfusion Reaction Investigation
(Pre and Post samples are required)
❑ Other _____

❑ HEA Genotyping (Molecular Phenotype)

Samples must be received by Tuesday at noon, results available by 8am on Thursday. STAT priority may be ordered on a case by case basis STAT TAT 24-36 hours (Sample received Monday- Thursday).

SEROLOGIC DATA/DIFFICULTIES

(Attach copy of work-up if available)

ABO/Rh Type: _____

DAT (Direct Antiglobulin Test):
Poly: _____ Anti-IgG:_____ Anti-C3b, C3d: _____

IAT (Indirect Antiglobulin Test – Antibody Screen):
❑ LISS-IAT ❑ PEG-IAT ❑ GEL ❑ Solid Phase

Screen Cell	IS	37°C	AHG / CC
I / 1			
II / 2			
III / 3			

PATIENT HISTORY

1. **PREGNANCY HISTORY:**
   CURRENTLY PREGNANT? ❑ **NO** ❑ **YES** ❑ **NA**
   # of Pregnancies: _____ # of Deliveries: _____
2. **TRANSFUSION HISTORY**: Has the patient received a red cell transfusion in **the past three (3) months?**
   ❑ **NO** ❑ **YES** (list date, # of units, facility)
   _____
   _____
3. **TRANSPLANT HISTORY:** Has Patient Received Stem Cell or Bone Marrow Transplant? ❑ **NO** ❑ **YES** If **YES**, Blood Type of Transplant: _____ Date: _____
4. **Daratumumab (Darzalex):** Has patient received daratumumab (Darzalex) in the last six (6) months?
   ❑ **NO** ❑ **YES** If **YES,** Date received: _____
5. **Rh IMMUNE GLOBULIN:** Has patient received Rh Immune Globulin in the last three (3) months?
   ❑ **NO** ❑ **YES** If **YES,** date received: _____
6. **ANTIBODY HISTORY:** Does the patient have any history of current or historical antibodies?
   ❑ **NO** ❑ **YES** If **YES,** please specify antibodies below:
   _____
7. Segments Sent? ❑ **NO** ❑ **YES**
   If yes, indicate unit number and segment number:
   Unit: _____ Segment: _____
   Unit: _____ Segment: _____
   Unit: _____ Segment: _____
   Unit: _____ Segment: _____

TRANSFUSION REQUIREMENT

A. If units do not need to be crossmatched and tagged by QualTex, then request for antigen negative units must be placed online via HemaControl **after** receipt of Preliminary Consultation Report.

B. If units need to be crossmatched and tagged by QualTex, then complete form **RL03.0040.1, Compatibility Testing Requisition.**

This Request Submitted By:

Name (Print): _____ Date: _____