Reg No. 52839081C

REQUEST FOR IMMUNOHAEMATOLOGY TESTS

Patient's Name Label

Note : Doctor's signature required on patient's sticky label of request form & specimen tube

For Downtime Use:
Name:
MRN:
Account Number:
Date of Birth:
Sex: M / F (Circle One)

Ward/Bed:___________ Clinic:___________ Class:___________

Patient Type ☐ Gynae ☐ Obst ☐ Neo ☐ Paed Medicine ☐ Paed Surgery

Clinical Diagnosis

Relevant History/Findings/Treatment

Name & Signature of Doctor collecting blood specimen

Pager / Contact No *(indicate if urgent)*

Name of Consultant I/C

Date

Laboratory Barcode **For Laboratory Use Only**		MT Sign
	Card Checked	
	LIS Checked	

Rh Control	FORWARD GROUPING				REVERSE GROUPING					
	Anti-D	Anti-A	Anti-B	Anti-AB	A cells	B cells	O cells	Blood Group	Rh (D)	Signature

	CDE	C	c	E	e	Sign
Patient Cells						
Positive Control						
Negative Control						
Probable Genotype						

Panel 1 ________________ Direct Coomb's Test __________________

Panel 2 ________________

Panel 3 ________________

BLOOD BANK Please (tick) appropriate boxes below

IMMUNOHAEMATOLOGY

IH0001P	☐	Paediatric ABO (for less than 4months old) (NOT FOR Blood Request)
IH0001	☐	ABO & Rh (D) Grouping (NOT FOR Blood Request)
IH0112	☐	Antibody screening (NOT FOR Blood Request)
XMB007	☐	ABO & Rh (D) Grouping & Antibody screening (NOT FOR Blood Request)
IH0030	☐	Direct Coomb's Test (Direct Antiglobulin test)
IH0020	☐	Titration of Antibodies
XMB010	☐	NNJ Profile - require separate request form for each specimen. Do not send if only 1 specimen is available
	☐	Mother : ABO & Rh (D) Typing Antibody Screen Anti A/B IgG Titre if ABO incompatible
	☐	Baby : Paediatric ABO Direct Coomb's Test
	☐	Others: pls specify ______________________