



REQUEST FOR IMMUNOHAEMATOLOGY TESTS

Patient's Name Label

Note : Doctor's name & 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 <input type="checkbox"/> Gynae <input type="checkbox"/> Obst <input type="checkbox"/> Neo <input type="checkbox"/> Paed Medicine <input type="checkbox"/> Paed Surgery	Laboratory Barcode For Laboratory Use Only	History MT Sign LIS Checked																																																																																						
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	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">Rh Control</th> <th colspan="4">FORWARD GROUPING</th> <th colspan="3">REVERSE GROUPING</th> <th rowspan="2">Blood Group</th> <th rowspan="2">Rh (D)</th> <th rowspan="2">Signature</th> </tr> <tr> <th>Anti-D</th> <th>Anti-A</th> <th>Anti-B</th> <th>Anti-AB</th> <th>A cells</th> <th>B cells</th> <th>O cells</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th></th> <th>CDE</th> <th>C</th> <th>c</th> <th>E</th> <th>e</th> <th>Sign</th> </tr> </thead> <tbody> <tr> <td>Patient Cells</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Positive Control</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Negative Control</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="7">Probable Genotype</td> </tr> </tbody> </table> <p>Panel 1 _____ Direct Coomb's Test _____</p> <p>Panel 2 _____</p> <p>Panel 3 _____</p>		Rh Control	FORWARD GROUPING				REVERSE GROUPING			Blood Group	Rh (D)	Signature	Anti-D	Anti-A	Anti-B	Anti-AB	A cells	B cells	O cells																																			CDE	C	c	E	e	Sign	Patient Cells							Positive Control							Negative Control							Probable Genotype						
Rh Control	FORWARD GROUPING				REVERSE GROUPING			Blood Group	Rh (D)	Signature																																																																														
	Anti-D	Anti-A	Anti-B	Anti-AB	A cells	B cells	O cells																																																																																	
	CDE	C	c	E	e	Sign																																																																																		
Patient Cells																																																																																								
Positive Control																																																																																								
Negative Control																																																																																								
Probable Genotype																																																																																								

BLOOD BANK Please (tick) appropriate boxes below

IMMUNOHAEMATOLOGY		
IH0001P	<input type="checkbox"/>	Paediatric ABO (for less than 4months old) (NOT FOR Blood Request)
IH0001	<input type="checkbox"/>	ABO & Rh (D) Grouping (NOT FOR Blood Request)
IH0112	<input type="checkbox"/>	Antibody screening (NOT FOR Blood Request)
XMB007	<input type="checkbox"/>	ABO & Rh (D) Grouping & Antibody screening (NOT FOR Blood Request)
IH0030	<input type="checkbox"/>	Direct Coomb's Test (Direct Antiglobulin test)
IH0021	<input type="checkbox"/>	Monospecific Direct Coomb's Test (Direct Antiglobulin test)
IH0020	<input type="checkbox"/>	Titration of Antibodies
XMB010	<input type="checkbox"/>	NNJ Profile - require separate request form for each specimen. Do not send if only 1 specimen is available
	<input type="checkbox"/>	NNJ Mother : ABO & Rh (D) Typing Antibody Screening Anti A/B IgG Titre if ABO incompatible
	<input type="checkbox"/>	NNJ Baby : Paediatric ABO Direct Coomb's Test
	<input type="checkbox"/>	Others: Specify _____