

Person Completing Requisition		
Institution	Client	
Dept	Physician	
Address		
City	ST	ZIP
Phone (Lab)	Phone (Physician)	



**WISCONSIN IMMUNOHEMATOLOGY REFERENCE LAB**  
 Phone 800-245-3117 x6205  
 Fax (414) 937-6461

<b>Patient/Sample Name</b>		Last			First			MI	
MR #				Accession #			SSN	-	-
DOB	/	/	Gender	<input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity	<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other			
Specimen Type	<input type="checkbox"/> EDTA/ Plasma <input type="checkbox"/> Clot tube/Serum <input type="checkbox"/> Other _____			Draw Date			Draw Time		
Fetal Specimen Type	<input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Cultured Amniocytes <input type="checkbox"/> CVS <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Fetal Blood <input type="checkbox"/> Other _____			/	/			:	
Special Reporting Requests:					PO#:			Phleb ID:	

**Medicare**

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? **Yes**  **No**   
**If yes, please complete our beneficiary form located at [www.versiti.org/medical-professionals/products-services/requisitions](http://www.versiti.org/medical-professionals/products-services/requisitions) and submit with this requisition.**

**Preliminary Results will be faxed to:** \_\_\_\_\_ **Results needed by (Date):** \_\_\_\_\_

**CLINICAL HISTORY:** Diagnosis: \_\_\_\_\_ Hgb/Hct: \_\_\_\_\_

Indication for Transfusion: \_\_\_\_\_ Total Number of Pregnancies: \_\_\_\_\_ (including miscarriages and abortions)

Known Antibodies: \_\_\_\_\_

Prior Transfusions:  Yes  No Patient Status:  Inpatient  Outpatient

Most recent date transfused: \_\_\_\_\_ # Units Transfused: \_\_\_\_\_ ABO/Rh of units: \_\_\_\_\_

**SEROLOGY**

**PLEASE ENCLOSE A COPY OF YOUR ABO/Rh, DAT, ANTIBODY SCREEN AND PANEL RESULTS**

- Antibody Identification (3060)  Antibody Titration (3080)  DAT Negative Workup (3111)  Donath Landsteiner
- Thermal Amplitude  Other (please specify) (3112) \_\_\_\_\_
- Drug-Dependent RBC Antibody Study (3110) – Drug: \_\_\_\_\_

**Please complete MEDICATION section on back of form (send >500 mg of suspected drug. Do not reconstitute.)**

Crossmatch Problem (IRL to crossmatch units) (3050) **Patient ID # used for transfusion:** \_\_\_\_\_

Number of units needed: Leuko-reduced RBC \_\_\_\_\_  CMV Neg  Irradiate  Other \_\_\_\_\_

PRENATAL (Fetal/Paternal) GENOTYPING		MOLECULAR													
Maternal Blood for MCC <u>must be submitted</u> with fetal sample		<input type="checkbox"/> Weak RhD Analysis (3040)													
Maternal Antibody(ies)		<input type="checkbox"/> Partial RhD Analysis (3240)													
Paternal Name:	DOB:	<input type="checkbox"/> Red Cell Genotyping Panel (44 Antigens) (3530)													
Paternal Blood (Recommended) Paternal Type (if known): _____ <input type="checkbox"/> N/A		<input type="checkbox"/> Red Cell Genotyping STAT Panel (24 Antigens) (3500)													
<input type="checkbox"/> RHD (3872)	<input type="checkbox"/> M/N (3864)	Comments:  <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p align="center"><b>Versiti Use Only</b></p> <table border="0"> <tr> <td>_____ EDTA</td> <td>_____ Clot</td> <td>Opened By _____</td> </tr> <tr> <td>_____ Amnio</td> <td>_____ CVS</td> <td>Evaluated By _____</td> </tr> <tr> <td>_____ Other _____</td> <td></td> <td>Reviewed By _____</td> </tr> <tr> <td></td> <td></td> <td>Labeled By _____</td> </tr> </table> </div>		_____ EDTA	_____ Clot	Opened By _____	_____ Amnio	_____ CVS	Evaluated By _____	_____ Other _____		Reviewed By _____			Labeled By _____
_____ EDTA	_____ Clot			Opened By _____											
_____ Amnio	_____ CVS			Evaluated By _____											
_____ Other _____				Reviewed By _____											
				Labeled By _____											
<input type="checkbox"/> K/k (3854)	<input type="checkbox"/> Fy(a)/Fy(b) (3860)														
<input type="checkbox"/> C/c (3850)	<input type="checkbox"/> Jk(a)/Jk(b) (3862)														
<input type="checkbox"/> E/e (3852)	<input type="checkbox"/> S/s (3866)														
<input type="checkbox"/> Js(a)/Js(b) (3858)	<input type="checkbox"/> Lu(a)/Lu(b) (3868)														
<input type="checkbox"/> Kp(a)/Kp(b) (3856)	<input type="checkbox"/> Do(a)/Do(b) (3870)														
<input type="checkbox"/> RhD Zygosity (Paternal Only) (3874)															

Versiti does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.

All samples must include sample identification clearly marked on **each** specimen container. Proper identification includes full name of individual, date obtained, hospital and/or patient identification number and the identification of the individual obtaining the specimen. Federal regulations mandate that a completed laboratory requisition form accompany each sample. Blood samples must be packaged to comply with requirements of mail or overnight courier service, if used.

**Shipping address:** Versiti Wisconsin - Immunohematology Reference Laboratory  
 638 N. 18th Street  
 Milwaukee, WI 53233  
 Phone: (414) 937-6205

**Recommended tubes for collection -- Do not use tubes that contain a silicone separator gel:**

Plain red top vacutainers for clotted (serum) samples -- Lavender/Pink top vacutainer with EDTA anticoagulant

SPECIMEN REQUIREMENTS	
SUSPECTED SEROLOGIC PROBLEM	REQUESTED AMOUNT
<b>Warm Autoimmune Hemolytic Anemia</b> – IAT Positive with all panel cells tested and a positive DAT (1+ - 4+) *For patients under 20 kg body weight, sample requirements will be adjusted depending on communication with patient's physician.	<b>No transfusion within the past 3 months:</b> 24mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top) <b>Transfused within the past 3 months:</b> 5mL EDTA whole blood (lavender or pink top) AND 30mL clotted whole blood (red top)
ABO Antibody Titers	10mL EDTA whole blood (lavender or pink top) OR 10mL clotted whole blood (red top)
Crossmatch Problem                      Antibody Antibody Identification                  Confirmation Transfusion Reaction                      Antibody Titration	5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top)
DAT Negative Autoimmune Hemolytic Anemia Study	10mL EDTA whole blood (lavender or pink top) AND 21 mL clotted whole blood (red top)
Thermal Amplitude or Donath-Landsteiner Test	5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top) tubes <b>prewarmed and maintained at 37°C during clotting and serum separated immediately</b>
Hemolytic Disease of the Newborn	Child – Cord blood sample (if available) Mother – 5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top)
Drug-Dependent RBC Antibody Study (complete the medication history listed below)	5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top) tubes AND <b>include a sample of each suspected drug</b>

MOLECULAR TESTS	REQUESTED AMOUNT
Rh D Discrepancy Analysis / Partial D Analysis	5mL EDTA whole blood (lavender or pink top)
Red Cell Genotyping Panel (44 Antigens)/ Red Cell Genotyping STAT Panel (24 Antigens)	5mL EDTA whole blood (lavender or pink top)
Prenatal Genotyping	<b>FETAL:</b> 7-15 mL Amniotic Fluid or 5-10 mg CVS <b>Backup Culture</b> (highly recommended): Two (2) T25 flasks Cultured Amniocytes or CVS (2 × 10 <sup>6</sup> minimum) <b>MATERNAL:</b> 3-5 mL EDTA whole blood for MCC (lavender top). <b>PATERNAL:</b> 3-5 mL EDTA whole blood

**MEDICATION** --- List all medications, prescription and non-prescription, taken in the past 30 days (include: aspirin, anticoagulants, oral contraceptives, or antibiotics)

Medication	Dose	Date Begun	Last Taken