CANADIAN BLOOD SERVICES - WINNIPEG CENTRE 777 William Avenue, Winnipeg, MB R3E 3R4 PERINATAL LABORATORY REQUEST FOR PERINATAL TESTING Physician/Authorized				PLEASE USE NAME PLATE OR PRINT PHIN (or Unique ID if no PHIN) LAST NAME						
Healthcare Pr				FIRST NAME						
	FULL Last Name and F			DOB	V – MA	M – D				
Facility:	YYYY - MM - DD									
	Clinic / Medical Record Number									
Phone No:										
Сс То:	FULL Last Name and F									
Clinic: Fax No:				NOTE: If sa	ample is f	from the	Father, ple	ease complete:		
	Mother's Na	ame:								
SAMPLE TYPE:     STAT     Father       Initial Visit     Antibody Referral				Mother's Pl	HIN or MF	RN:				
26-28 Weeks Kleihauer-Betke (gestational ageweeks)				Mother's Ex	Mother's Expected Delivery Date:					
└ At Delivery └ Other				Collected a	at:					
Expected Delivery Date:			Facility				Ward			
Expected Der	Ivery Date	YYY - MM - DI	D	Phlebotom	ist:					
Antibodies: Yes No Describe										
Transfusion: Yes No Date			Print Name	Print Name Classification Initials						
RhIG given: Yes No Date				Collection	Collection Date: Time					
Sample collected before RhIG was given See Yes No					Ň	YYYY- N	/M - DD	11110		
			Guidelines for	or Perinatal Tes	sting					
		L-14 - 1 X B - 14	Father	26 - 28 W	eeks	Post F	Partum	Cord Blood	As Requested	
		Initial Visit	i alliei		00110				As nequested	
Rh Unknown 1s		Х	T ather	X **					As nequested	
Rh Positive Pre	st Pregnancy vious CBS Report on File	X X		X **						
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Date / Time Received at Centre

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