PATIENT REQUEST FOR ANTI-IgA TESTING

Canadian Blood Services — BLOOD PLASMA STEM CELLS ORGANS & TISSUES

SECTION A: PATIENT INFORMATION (MUST BE COMPLETED)		
Surname:	**Given Name:**	
D.O.B. (yyyy-mm-dd):	**Date Collected (yyyy-mm-dd):**	**Patient Identification Number:**
Gender: ☐ **Male** ☐ **Female**		

SECTION B: CONTACT INFORMATION AND TESTING INFORMATION	
Institution/Hospital:	**Address:**
Requesting Physician:	
Phone:	
Fax:	

REASON FOR REQUEST: ☐ **Anti-IgA Testing**

1. **Transfusion Reaction:**
   - ☐ **Anaphylactic**
   - ☐ **Other:** _____

2. **Patient Requires Transfusion:**
   - ☐ **Known low or IgA deficient (blood component therapy or plasma product therapy)**
     IgA level, if known: _____ **mg/dL.**
   - ☐ **Transfusion date (yyyy-mm-dd):** _____

SECTION C: SAMPLE REQUIREMENT

Sample required: Minimum 2 mL separated SERUM. Wrap sample caps with parafilm.
Label sample with the following: Name, ID Number, Collection Date, Date of Birth
Sample MUST be sent FROZEN with DRY ICE to local Canadian Blood Services Site.

Sample Prepared by:	**Date (yyyy-mm-dd):**	**Package Date (yyyy-mm-dd):**

FOR CANADIAN BLODD SERVICES USE ONLY

Sample Packed by (Initials/Date): _____ ☐ N/A

Canadian Blood Services Site Medical Officer/Designate Review

Initials: _____ Date: _____

SECTION D: FOR BRAMPTON USE ONLY

☐ **N/A ALIQUOTTING**

Prepared by (Initials/Date):	Sample Aliquoted by (Initials/Date):	Verified by (Initials/Date):