REQUEST FOR RHD GENOTYPING

Section A - Patient Information			
Surname:		**Given Name:**	
PHN/HCN:	**Hospital Number:**	**Sex:**	**D.O.B** *(dd-mmm-yyyy):*
Serological ABO and RhD type:		**Ethnicity:**	
Does patient have Sickle Cell Disease? ☐ No ☐ Yes **Other hemoglobinopathy?** ☐ No ☐ Yes, specify:			
Is this a perinatal patient? ☐ No ☐ Yes **Specify if other clinical diagnosis:**			
Transfusion History: ☐ No ☐ Yes, date last transfused *(dd-mmm-yyyy):* ☐ Unknown			
Ongoing transfusion requirement? ☐ No ☐ Yes			
Stem Cell/Bone Marrow Transplant? ☐ No ☐ Yes, date *(dd-mmm-yyyy)*: ☐ Autologous ☐ Allogeneic			

Section B – Reason for Request *****Please attach serology results*****

- ☐ **Weak, variable or discrepant RhD phenotype**
- ☐ **Assessment for D variant in hemoglobinopathy**
- ☐ **Anti-D with serologic RhD positive phenotype**
- ☐ **Other:**

CBS NIRL use only: ☐ Reflex testing ☐ Donor investigation ☐ Serology investigation ☐ Other:

Section C - Referring Facility Information		
Name of Institution:		
Street Address:		
City:	**Province:**	**Postal Code:**
Email:	**Phone:**	**Fax:**
Laboratory Supervisor/Referring Physician:		

Section D - Sample Information

Sample Collection Date: ______________________ *(dd-mmm-yyyy)* **Shipping Date:** _____________________ *(dd-mmm-yyyy)*

- Submit EDTA (purple top) specimen- minimum 2ml of whole blood
- Samples **must be labelled** with the patient's name, a unique identifying number (not date of birth), and collection date.
- Samples must be received by CBS Edmonton Centre- Diagnostic Services Laboratory for testing within 14 days of sample collection

Notify Edmonton Diagnostic Services when submitting sample by faxing copy of completed requisition to **780-431-8779**

General inquiries may be directed to genotyping.edm@blood.ca or by phoning **780-431-8765**

Ship to:
Canadian Blood Services
Diagnostic Services Laboratory
8249-114 Street
Edmonton AB T6G 2R8

For CBS Edmonton Sample Label