REQUEST FOR PATIENT BLOOD GROUP GENOTYPING

Canadian Blood Services — BLOOD PLASMA STEM CELLS ORGANS & TISSUES

Section A - Patient Information (Must be Completed)			
Surname:	**Given Name:**		
D.O.B (dd-mmm-yyyy):	**Gender:** ☐ Male ☐ Female	**PHN/HCN:**	**Hospital Number:**
Ethnicity: ☐ Caucasian ☐ African Descent ☐ Latin-American ☐ Indigenous ☐ Asian ☐ Other_____ ☐ Unknown			
Clinical diagnosis/ pre-existing condition(s):			
Ongoing transfusion requirement? ☐ Yes ☐ No			
Transfusion History: ☐ No ☐ Unknown ☐ Yes, date transfused: **(dd-mmm-yyyy)** — **Transfusion Reaction:** ☐ Yes ☐ No			
ABO/Rh:	**RBC Phenotype:**		
Antibodies in Serum (Allo, Auto):			

Section B - Testing Information

Reason for Request:

- ☐ **Predict RBC phenotype of recently transfused patient**
- ☐ **Positive direct antiglobulin test (DAT)/AIHA**
- ☐ **Resolution of complex antibody identification and/or distinguish alloantibody from autoantibody**
- ☐ **Confirmation of rare phenotype**
- ☐ **Prenatal testing for weak or partial RhD phenotype**
- ☐ **Confirmation of weak or partial RhD phenotype**

Other (please provide additional information): _____

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

Section D - Sample Information:	
▪ Submit EDTA (purple top) specimen- minimum 2ml of **whole blood** ▪ Samples **must be labelled** with patient's name, a unique identifying number (**not date of birth**), and collection date ▪ Sample must be received by CBS laboratory within 14 days of sample collection	**Sample Collection Date: (dd-mmm-yyyy)**

FOR CBS USE ONLY **Sample Number Label:**