

Diagnostic Services Antibody Investigation Request Form



Monday – Friday 0800 - 1700
Phone: (604) 707-3444 Fax: (604) 874-6582
After hours urgent requests - Phone (604) 876-7219

4750 Oak St
Vancouver, BC
V6H 2N9

Date: dd-mmm-yyyy Hospital:

Technologist: Telephone: Ext:

Samples to be transported by: Waybill#

Date sent: dd-mmm-yyyy Expected date/time of arrival: dd-mmm-yyyy hh:mm

**NOTE: Please fax this form to 604-874-6582 when packing. Include original forms with samples.
After hours fax to 604-879-6669.**

Patient Information (See reverse side for specimen shipping instructions)

Sample collection date: dd-mmm-yyyy Name: Surname First name(s)

Birthdate: dd-mmm-yyyy Sex: M F PHN:

Physician: Diagnosis:

Transfusion History: Has patient been transfused in the last 3 months: Yes No
If transfused with red cells, indicate date(s) of transfusion and ABO/Rh of transfused red cells (dd-mmm-yyyy):

Reactions? Yes No. If Yes, type: _____

Previous Pregnancies? Yes No

If RhIG was administered within last 6 months, provide date(s) of injection (dd-mmm-yyyy):

ABO/Rh: Direct Antiglobulin Test: Gel Tube Poly: Anti-IgG: Anti-C3:

Phenotype available No Yes. If yes, attach computer record or copy of phenotype worksheet.

Previous antibodies: CBS reference no:

Urgency <input type="checkbox"/> Not Urgent <input type="checkbox"/> ASAP <input type="checkbox"/> Urgent	Interim Report Fax to:
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Note: If phenotyped donor units are required, please fax a Special Request Order Form to CBS order desk/distribution.

Reason for Antibody Unidentified Antibody ABO/Rh Typing Anomaly
Investigation Request: Positive DAT Other _____

Test Method used: _____

Comments:

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Comments:

INSTRUCTIONS FOR SENDING BLOOD SAMPLES:

1. Please send three 7mL EDTA samples.
2. If a transfusion reaction is suspected, include pre- and post-transfusion samples.
3. Label all tubes clearly. Include full name, date of birth, PHN and date collected.
4. Include a small sample (5-10 drops) of the reactive cells, or donor segments if an antibody to a low incidence antigen is suspected.
5. Please enclose copies of the crossmatch requisition, screening cell antigen profiles, panel sheets and phenotyping worksheets whenever possible.

WHEN SUBMITTING ALL ANTIBODY INVESTIGATION REQUESTS PLEASE FAX THE FRONT COPY OF THIS FORM TO 604-874-6582 AND CONTACT THE ANTIBODY INVESTIGATION LAB 604-707-3444 BY PHONE.

URGENT – AFTER HOURS – FAX THIS FORM TO 604-879-6669 AND CONTACT THE TECHNOLOGIST ON CALL AT 604-876-7219.