

TM GENOTYPING FOR RED CELL ANTIGENS REQUISITION

*REQUIRED INFORMATION		*PROVINCE	PERSONAL HEALTH NUMBER (PHN) (OPTIONAL)	*REGIONAL HEALTH RECORD NUMBER
SUBMITTING LABORATORY Name		*PATIENT LAST NAME		*FIRST NAME
Location: _____		MIDDLE NAME		
5 digit Facility Alias #:		PATIENT ADDRESS		CITY, PROVINCE
Alpha Provider#:		POSTAL CODE		
FAX RESULTS TO: (Full Name and #) _____		CHART NUMBER	*GENDER	*DATE OF BIRTH
SUBMITTING LAB SPECIMEN NUMBER (Use all digits, even zeros):				PATIENT PHONE NUMBER
			Y Y Y Y / M M M / D D	() - - - -
		Specimen Collection		
		Collected by	*Collection date	*Collection time
		*Encounter Type: <input type="checkbox"/> Outpatient Manual (Calgary Rural Laboratories) <input type="checkbox"/> Extra Regional Specimen Outpatient (within Alberta) <input type="checkbox"/> Referred in Specimen (Out of Province)		
*DATE SUBMITTED		*Financial Class: <input type="checkbox"/> Bill Company <input type="checkbox"/> AB PHN (Rural Laboratories) <input type="checkbox"/> Out of Province		
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***Patient/Clinical Data**

Transfusion: None Transfusion History Attached

Currently pregnant: EDC:

Diagnosis (es):

Bone marrow/stem cell transplant: Date:

Ethnic Background: Caucasian Hispanic Aboriginal Asian Other - Specify: Unknown

Comments:

***Reason for Genotyping Request**

Predict/confirm RBC phenotype in recently transfused patient

Complex antibody investigation / autoantibody Antibodies suspected:

Confirmation of rare/unusual phenotype Specify:

Provision of phenotypically matched blood

Other Specify:

Specimen Instructions

<p>Specimen requirements:</p> <ul style="list-style-type: none"> • EDTA • Minimum 4 mL • Specimen tube must not be opened or entered by an instrument probe 	<p>Send specimen to</p> <p>Alberta Precision Laboratories Attention: Transfusion Medicine Foothills Medical Centre 7th Floor Laboratory, McCaig Tower 1403 29th St. NW Calgary AB T2N 2T9</p>
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FOR APL TM USE ONLY					ACCESSION NUMBER
Specimen received		Testing approved			
Date	Time	By	Date	Time	