NewYork-Presbyterian

506 6th Street, 2nd Floor Room 2008
Brooklyn, New York 11215

DOWNTIME BLOOD BANK TEST REQUISITION FORM

ACCOUNT NO.
MED. REC. NO.
PATIENT NAME:
DOB:

Note: All specimens for pre-transfusion testing must be labeled at the patient's bedside with patient's full name, MR#, date collected,and phlebotomist signature.

PLEASE COMPLETE THE FOLLOWING:

Location:_____ Phone:_____Ordering Physician: _____

Collected by:_____Date and time: _____Patient transfused last three months ____Yes ____No Patient is pregnant _____Yes ____No Patient is a Sickle _____Yes ___No

Blood Test Transfusion Service Work Requested: (PINK TOP TUBE (K2EDTA)

_____Type and Screen _____ABORH Confirmation _____Direct Anti-Globulin Test

_____Heel Stick New Born Profile Test _____Fetal Maternal Hemorrhage Screen FMHS

_____Cord Blood Routine _____Other (specify) _____

TRANSFUSION SERVICE USE ONLY: **RECEIVED DATE/TIME:** _____ **ACC#**_____

Attach any Instrument print out to this requisition
Result Entered into LIS by: _____**Date:** _____
Result entries accuracy confirmed by: _____ **Date:** _____

ABO/RH TYPE REVIEW OF HISTORY: ____YES _____NO **SAMPLE NUMBER**:

Reagents	anti-A	anti-B	Anti-D	D CTRL	A1 cell	B cell	ABO/Rh Interpretation	Tech ID	Date
Type									

ANTIBODY SCREEN OTHER TESTS/COMMENTS:

Reagents	Cell 1	Cell 2	INTERP	ABID	Eluate	Tech ID	Date
Ab Screen							

DIRECT ANTIGLOBULIN TEST DAT

Reagents	PS IS	PS 5'RT	Ctrl	IgG IS	CTRL	C3bd IS	C3bd 5'RT	CTRL	Tech ID	Date
DAT										

COMPATIBILITY TESTING

Crossmatch (donor unit #)	**Acc#**				**XM Interp.**	**Tech ID**	**Issue Date/Time**	**Tech ID**
	IS	**37° C**	**AHG**	**Ctrl**				
Donor 1								
Donor 2								

- **Fetal Bleed Screen**: POS_____NEG _____ Positive Ctrl____ Negative Ctrl____ Lot# _____EXP. Date_____ Performed by: _____

- **Antigen Testing** for _____ POS_____NEG _____ Positive Ctrl____ Negative Ctrl____ Lot# _____EXP. Date_____ Performed by: _____

Reviewed By: _____ Date:_____