Saskatchewan Health Authority
Transfusion Medicine Laboratory
Phone: RUH - (306) 655-2179 SCH – (306) 655-8204 SPH - (306) 655-5168
Phone: Humboldt – (306) 682-8128

PATIENT IDENTIFICATION

FIRST NAME: _____

LAST NAME: _____

HSN: _____

D.O.B.: _____

TML TEST REQUEST FORM

Saskatoon and Humboldt hospital site use only. All unshaded sections MUST be completed (see reverse for details).

Collection Information			Lab Use Only
Site: ❑ RUH ❑ JPCH ❑ SCH ❑ SPH ❑ Humboldt ❑ Other:			Previous Group:
Ward:	Phone #:	Fax #:	Known Antibodies:
Date & Time Required:			Special Requirements: ❑ IRR ❑ Other (list below)
Priority: ❑ Stat ❑ Urgent ❑ Routine (within 24 hours of receipt)			
Requesting MRHP:			
Copies to:			Ordered in LIS: ❑ TS/COND ❑ RPGRP ❑ ABORH ❑ PVTS ❑ PVGRH ❑ PVRPT ❑ BTS/COND ❑ RBGR ❑ BGRH ❑ ABOC ❑ ABOCI ❑ ABOCX ❑ CORD ❑ KBT ❑ DAT ❑ CVS ❑ Specimen Rec'd in LIS ❑ Other:
Patient Information			
ABO & Rh Group (if known):			
Diagnosis:		❑ Sickle Cell Disease ❑ Thalassemia	
Indication for test:			
Transfused in last 3 months? ❑ No ❑ Yes – Where? _____ ❑ Unknown			
Pregnant in last 3 months? ❑ No ❑ Yes ❑ Unknown			Date & Time Rec'd:

Tests Requested (LIS code BBSPC)	
Collection and identification signatures required	**Only collection signature required**
❑ ABO Group and Rh Type*	❑ ABO/Rh Confirm
❑ Collect and Hold Specimen*	❑ Cold Screen (Cardiovascular Surgery only)
❑ Group and Screen*	❑ Cord Blood Testing
	❑ Direct Antiglobulin Test (DAT)
	❑ Test for Fetal Hemoglobin (Kleihauer-Betke)
*Pre-transfusion/pre-transplant testing **requires signatures from TWO DIFFERENT persons**	❑ Transfusion Adverse Event Investigation (complete TAER form)
	❑ Other:

Patient Identification and Collection **IMPORTANT: Specimens will be rejected if required signatures are incomplete**	
Collected By (**All** specimens): Printed Name Signature	Date of Collection: DD MM YYYY Time: HH:MM
Identified By **(Required from a second person for all test marked with *)**: Printed Name Signature	Date of Identification: DD MM YYYY Time: HH:MM

Complete this section for infants less than 4 months of age	
Mother's Name:	Mother's HSN:
Mother's Blood Group (if known):	Infant's Birth Weight (grams):

Lab Use Only – Documentation of Communication with Care Provider				
Date:	Time:	Ward:	Person Contacted:	Tech:
❑ Req not signed ❑ New specimen required ❑ Results faxed/printed to: _____ ❑ Other:				

TML TEST REQUEST FORM

Identification

- Specimens **must** be labelled with the patient's first and last name, date of collection **and** the Health Services Number (HSN) or other unique identification number

Specimen container (refer to Saskatoon Health Region Lab Services Manual)

- EDTA – 1 x 3-4 mL (lavender top)
- Other: Refer to Laboratory Services Manual for information on specimen requirements

Patient Identification for Pre-transfusion or Pre-transplant Collection

- **A two-person patient identification process must be done at the patient's side**.
- The person who collects the patient's specimen verifies the patient's identity. Compare the patient's full name, date of birth, and health services number on the identification band with the corresponding information on the requisition. **Patient information must agree**.
- The collector prints and signs their name, and records the specimen collection date and time on the requisition. If the collector is unable to sign, a designate may print the collector's name and sign their own name on the form.
- The person who confirms the identity of the patient **must be different** from the person who collects the specimen. If able to communicate, the patient may self-identify or a second person (e.g., family member, friend, healthcare provider) may identify the patient. The patient or second person identifier must be able to state at least the patient's full name (first and last name) and date of birth. **Patient information must agree**. The collector must obtain the signature of the identifier.

Patient Second Blood Group (ABO/Rh Confirm)

- A second specimen, collected at a separate phlebotomy, is required if there is no reliable record of a previous blood group (ABO/Rh) for the patient.
- The ABO/Rh Confirm sample **must be collected at a different time** than the pre-transfusion specimen, and **should be obtained by a different collector**.
- Communication from TML will be received when confirmatory ABO/Rh collection is required.

Rejection Criteria

- Pre-transfusion specimens
    - Unlabeled, illegibly-labelled, mislabeled, or inadequately labelled specimens
        - Original labeling **must be** present and visible
    - Incomplete, inaccurate, or illegible information on the requisition
    - Discrepancies between requisition patient information and specimen label information
    - Incomplete or missing documentation
        - Collected by – required for **all** collections
        - Identified by – required for those tests indicated by * on front of form
        - Date and time of collection
- All other specimens
    - Refer to test specific Lab Services Manual document

Test Definitions

- **ABO Group and Rh Type*** – a pre-transfusion test to determine the specific ABO group and Rh type of the patient only.
    - Eg. To determine if WinRho administration is required for pregnant Rh Negative mothers
- **ABO/Rh Confirm** – a second specimen which may be requested by the TML for ABO Group & Rh Type confirmation if a historical blood group result is unavailable, to allow for ABO group-specific red blood cells to be issued for transfusion.
- **Cold Screen** – test which may be performed if a clinically significant cold agglutinin antibody is suspected in preparation for cardiovascular surgery
- **Collect and Hold*** – a specimen collected according to standard pre-transfusion procedure and sent to the TML to be held, in case the need for pre-transfusion testing becomes necessary. A phone call to TML is required to request testing of this collected specimen.
    - Eg. Patient presentation to ER with a normal hemoglobin who is stable at the time of blood collection, but may be at risk of bleeding and transfusion
- **Cord Blood Testing** – includes an ABO Group & Rh Type, Direct Antiglobulin Test and red blood cell phenotyping (in select cases) on cord blood cells of newborn babies.
    - Eg. To determine the risk of hemolytic disease of the fetus and newborn (HDFN) in mothers with known red blood cell alloantibodies, or who are Group O
    - Eg. In Rh Negative mothers, to determine the need for post-partum WinRho administration
- **Direct Antiglobulin Test** (DAT) – in a case of suspected red blood cell hemolysis, checks for the presence of IgG antibody or complement on the cell surface
- **Group and Screen*** – pre-transfusion tests to determine the patient ABO group and Rh type, and check for non-ABO antibodies. Results must be available before crossmatched red blood cells can be issued.
- **Test for Fetal Hemoglobin** (Kleihauer-Betke) – a test to measure the amount of fetal blood in the maternal circulation.
    - Eg. Rh Negative women to ensure proper WinRho dosing
    - Eg. in the setting of significant fetal-maternal hemorrhage (trauma to a pregnant woman; placental abruption, etc.)
- **Transfusion Adverse Event Investigation** – post-transfusion specimen collected for investigation in the setting of a serious adverse transfusion reaction.
- **Other** – request of a test by TML not otherwise listed, which may include: red blood cell phenotyping for specific antigens, isohemagglutinin titers, cold agglutinin testing outside the setting of surgery.

The asterisk (*) denotes pre-transfusion or pre-transplant specimens, which require both collection and identifications signatures on the requisition.