Benefits of providing COMPLETE and LEGIBLE information:

- Reduces turn around time when processing patient samples
- Promotes patient safety through reduced transcription errors

Patient Identification MUST include:

- ✓ First and last name
- ✓ PHN or unique identifier
- ✓ Date of Birth

TML TEST REQUEST FORM

D.O.B.: _____

Failure to supply required information will lead to delays in service

Saskatoon and Humboldt hospital site use only. All unshaded sections MUST be compl

Collection Information			
Site: ❑ RUH ❑ 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:			Order

Collection/Patient Information sections MUST be FULLY completed

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:

ABORH
PVRPT
BGRH
BT
ABOC
ABOCI
ABOCX
❑ CORD ❑ KBT ❑ DAT
❑ CVS
❑ Specimen Rec'd in LIS
❑ Other:

Tests Requested (LIS code BBSPC)	
Collection and identification signatures required	Only collection signat
❑ ABO Group and Rh Type*	❑ ABO/Rh Confirm
❑ Collect and Hold*	❑ Cold Screen (Cardiovascular Surgery or
❑ Group and Screen*	❑ Cord Blood Testing
	❑ Direct Antiglobulin Test (DAT)
	❑ Test for Fetal Hemoglobin (Kleihauer-B
*Pre-transfusion/pre-transplant testing **requires signatures from TWO DIFFERENT persons**	❑ Transfusion Adverse Eve investigatio
	❑ Other:

Patient Identification and Collection information must be completed by the person responsible for these actions.

Witness of collection may be utilized when the collector is unable to sign. The witness will then indicate the collectors name in 'Collected By' and then sign 'Witness of Collection'.

Failure to complete this section will result in specimen rejection.

Patient Identification and Co
IMPORTANT: Specimens will be rejected if required sig
Collected By (**All** specimens): Printed Name _____ Signature _____ Date Time
Identified By **(Required from a second person for all test marked with *)**: Printed Name _____ Signature _____ Date Time

Infants less than 4 months of age MUST include Mother's information

Complete this section for infants less than 4 months of age	
	Mother's HSN:
wn):	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:				