National Center for Blood Group Genomics – Testing Request Form

Sample Type: □ Whole Blood  □ Buccal Swabs  □ Amniocytes

*Name: Last ___________________ First: ___________________ Middle: ________________
Identification Number: ___________________ Birth Date ___________ Race: _______________
*Date Collected _______________ *Date Submitted ___________________ *Sex _______________
*Hospital/Facility ____________________________________________________________
*Physician Requesting Test(s) __________________________________________________
  Information on test methods, performance specifications and interpretation are available on request.
  *CLIA Required Information, CFR 493.1241

Clinical History: Diagnosis _______________________________________________________
Antibody ID: ___________________________ Antigen Type: ___________________________
Prior transfusions: □ Yes □ No
Date of most recent red cell transfusion _____________________ Number ______________
Pregnancy: Is patient now pregnant? □ Yes □ No  Gravida _______ Para _________
Stem Cell Transplant: □ Yes □ No  Date: _________

Test Requested:
Red Cell:
□ BioArray HEA Precise Type Panel   □ Agena: Hemo ID™ Panel
□ Genotype, RHD (weak/partial D)    □ Genotype, Rh Common: □ D □C/c □ E/e
□ RHD Zygosity                    □ Genotype, ABO (subgroup)
□ Genotype, RHCE (variant)        □ Genotype, Blood Group Antigen _________

Platelet Antigen Typing:
□ Genotype, HPA (HPA1-9,11,and15) Panel  □ Genotype, HPA-1a, (PLA1)

Other: □ Please Specify _________________________________________________________

Comments: _________________________________________________________________

Acceptable anticoagulants for whole blood samples:
• EDTA (lavender / pink top) or
citrate (yellow top) –ACD type A
• Lithium heparin discouraged because heparin may interfere with Polymerase Chain Reaction (PCR).

Date: __________  Personnel authorized to request tests/receive results: ___________________
FAX: _______________________________  Telephone: _______________________________
SAMPLE REQUIREMENTS:
Whole blood samples should be < 10 days old and have volume between 7-10 mL and should be stored at 2-8°C. See Acceptable anticoagulants on page 1.

LABEL REQUIREMENTS:

| Patient Sample | All patient samples must have at least two identifiers. Acceptable identifiers include:  
|                | • Patient’s first and last name,  
|                | • Patient’s date of birth, or  
|                | • Patient identifying # (MR Number) |
| Donor Sample   | Donor samples can be labeled with the following:  
|                | • Donor Name or Donor ID number assigned by the customer  
|                | • Donor Unit number  
|                | Note: A single identifier is acceptable for donor samples. |
| DNA or Study Sample Label Information | DNA samples are acceptable with prior approval/consultation and may have one identifier, if being tested for non-patient related care, are research related or part of an anonymous clinical trial. The identifier may be one of the following:  
|                | • Name  
|                | • Donor Name or Donor ID number assigned by the customer  
|                | • Donor Unit number |

PROCEDURE FOR SENDING SAMPLES:
1. Fill out the National Center for Blood Group Genomics request form and provide the necessary information.  
2. Notify the National Genomics Laboratory by telephone before sending samples.  
3. Pack the sample in a secured protective manner to avoid breakage. Ensure paperwork is separated from the sample.  
4. Ship all samples in plastic bags at room temperature or refrigerated using ice packs or wet ice.