# Request for Patient Blood Group Genotyping

Canadian Blood Services
it's in you to give

| Section A - Patient Information (Must be Completed) | | | |
|---|---|---|---|
| Surname: | | Given Name: | |
| D.O.B: _____ yyyy/mmm/dd | Gender: ☐ Male ☐ Female | PHN/HCN: | Hospital Number: |
| Ethnicity: ☐ Caucasian ☐ African descent ☐ Hispanic ☐ Aboriginal ☐ Asian ☐ Other_____ ☐ Unknown | | | |
| Clinical Diagnosis/ Pre-existing condition(s): | | | |
| Ongoing transfusion requirement? ☐ Yes ☐ No | | | |
| Transfusion History: ☐ No ☐ Unknown ☐ Yes, date units transfused: Transfusion Reaction: ☐ Yes ☐ No | | | |
| RBC phenotype (attach copies of related RhD serology results): | | | |
| Antibodies in serum (allo, auto): | | | |

**Section B - Testing Information**

Reason for Request:

- ☐ Predict RBC phenotype of recently transfused patient
- ☐ Positive direct antiglobulin test (DAT)/AIHA
- ☐ Resolution of complex antibody identification and/or distinguish alloantibody from autoantibody
- ☐ Confirmation of rare phenotype
- ☐ Prenatal testing for weak or partial RhD phenotype
- ☐ Confirmation of weak or partial RhD phenotype

Other (please provide additional information): _____

| Section C - Referring Facility Information: | | |
|---|---|---|
| Name of Institution: | | |
| Address: | | |
| City: | Province: | Postal Code: |
| Phone Number: | Fax Number: | |
| Laboratory Supervisor/Referring Physician: | | |

**Section D - Sample Information:**

Sample Collection Date: _____ (yyyy/mmm/dd) Shipping Date: _____ (yyyy/mmm/dd)

- Samples **must be labeled** with patient's name, a unique identifying number (**not date of birth**), and collection date.
- Submit EDTA (purple top) specimen- minimum 2ml of **whole blood**
- Samples must be received by CBS Laboratory for testing **within 14 days of sample collection**

FOR CBS USE ONLY:

Date and Time received: _____

Receiver Initials: _____

CBS Sample Number:



F801221 (2018-05-22)