Request for RHD Genotyping

Canadian Blood Services — BLOOD PLASMA STEM CELLS ORGANS & TISSUES

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):

Transfusion History:
☐ No ☐ Unknown ☐ Yes, date units transfused: **Ongoing transfusion requirement?** ☐ No ☐ Yes

RBC phenotype (serology): **Known antibodies (allo, auto):**

Stem Cell/Bone Marrow Transplant: ☐ No ☐ Yes, ☐ Autologous ☐ Allogeneic **Transplant date:**

Section B - Testing Information

Reason for Request:

☐ 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:

Street Address:

City:	**Province:**	**Postal Code:**
Email:	**Phone:**	**Fax:**

Laboratory Supervisor/Referring Physician:

Section D - Sample Information:

Sample Collection Date: _____ **Shipping Date:** _____
yyyy/mmm/dd yyyy/mmm/dd

- Submit EDTA (purple top) specimen- minimum 2ml of **whole blood**
- Samples **must be labelled** with patient's name, a unique identifying number (**not date of birth**), and collection date.
- Samples must be received by CBS Edmonton Centre- Diagnostic Services Laboratory for testing **within 14 days of sample collection**
- Notify Edmonton Diagnostic Services when submitting sample by faxing copy of completed requisition to 780-431-8779
- General inquiries may be directed to genotyping.edm@blood.ca or by phoning 780-431-8765

Ship to:

Canadian Blood Services
Diagnostic Services Laboratory
8249-114 Street
Edmonton AB T6G 2R8

FOR EDMONTON DIAGNOSTIC SERVICES USE ONLY:

Sample label applied to genotyping sample log **Initials:** _____

Sample Label