

CANADIAN BLOOD SERVICES - WINNIPEG CENTRE

777 William Avenue, Winnipeg, MB R3E 3R4
PERINATAL LABORATORY

REQUEST FOR PERINATAL TESTING

Physician/Authorized
Healthcare Provider: _____

FULL Last Name and FULL First Name must be recorded.

Facility: _____

Phone No: _____ Fax No: _____

Cc To: _____

FULL Last Name and FULL First Name must be recorded.

Clinic: _____ Fax No: _____

SAMPLE TYPE: STAT _____ Father
 Initial Visit Antibody Referral
 26-28 Weeks Kleihauer-Betke (gestational age _____ weeks)
 At Delivery Other _____

Expected Delivery Date: _____

YYYY - MM - DD

Antibodies: Yes No Describe _____

Transfusion: Yes No Date _____

RhIG given: Yes No Date _____

Sample collected before RhIG was given Yes No

PLEASE USE NAME PLATE OR PRINT

PHIN (or Unique ID if no PHIN) _____

LAST NAME _____

FIRST NAME _____

DOB _____
YYYY - MM - DD

Clinic / Medical Record Number _____

NOTE: If sample is from the Father, please complete:

Mother's Name: _____

Mother's PHIN or MRN: _____

Mother's Expected Delivery Date: _____
YYYY - MM - DD

Collected at:

Facility _____ Ward _____

Phlebotomist:

Print Name _____ Classification _____ Initials _____

Collection Date: _____ Time _____
YYYY - MM - DD

Guidelines for Perinatal Testing

	Initial Visit	Father	26 - 28 Weeks	Post Partum	Cord Blood	As Requested
Rh Unknown 1st Pregnancy	X		X			
Rh Positive Previous CBS Report on File	X		**			
Rh Negative	X	If requested	X	X	X	
Clinically Significant Antibodies Detected	X	X		X	X	X

**** 28 Week or additional sample may be submitted for patients at risk of allo-immunization (previous transfusion, fetal trauma or procedure, IV drug use).**

Step	Responsibilities of Phlebotomist (person collecting the sample)	Comments
1	The phlebotomist must positively identify the patient	
2	The phlebotomist must collect 2 x 7ml EDTA (lavender top)	
3	The phlebotomist must label the sample(s) using indelible ink. Label the sample(s) immediately after the collection and before leaving the patient's side with <ul style="list-style-type: none"> Personal Health Identification Number (PHIN), or hospital number, (If PHIN is not available or patient is from out of province), or other unique identification number the patient's last name, first name the collection date facility name, and phlebotomist's initials. (Initials must match name on requisition) 	
4	The phlebotomist must complete the requisition by <ul style="list-style-type: none"> Printing his/her name, classification, and initials, and recording the date and time of collection. 	
5	Error Correction <ul style="list-style-type: none"> Cross out the erroneous information with a single line, record the correct information, and initial the correction Use of correction fluid or correction tape will result in rejection of sample. 	

Accession Number	Demographics Agree with Historical Records	Entered By	Reception	Verification
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No File			

Date / Time Received at Centre