TO REORDER FORMS CALL 425-656-3022

REQUEST FOR TESTING TRANSFUSION SERVICES

Bloodworks Northwest
921 Terry Avenue • Seattle, WA 98104-1256

BW Tech	BW ID / CL #

Time Received

See back of form for sample requirements. Current test descriptions and CPT codes may be viewed at http://www.bloodworksnw.org/laboratories/tests/index.htm Shaded areas for BW use only.

COMPATIBILITY TESTING LABORATORY (CTL) Laboratory Staffed for Questions and Results Daily, 24 Hrs./Day

Phone: Central (206) 689-6525 | Overlake (425) 467-3374 | SKL (425) 656-7900 | Evergreen (425) 434-4949 | Children's (206) 987-5151

TESTING PROFILES – Battery of test in Profiles are listed on the back of this form.

3103-00/3104-00 ☐ Prenatal profile.
Date Antepartum RhIg issued _____

3103-00/3104-00 ☐ Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin
3145-00

3103-00/3104-00 ☐ Extended Postnatal Profile (for Mother) no Fetal Bleed Screen

3103-00/3125-00 ☐ Extended Postnatal Profile (for Baby)
Mother's name _____

3103-00/3104-00 ☐ Potential Donor Profile

3103-00/3104-00 ☐ Potential Transplant Recipient Profile

Immunohematology Reference Laboratory (IRL) Phone (206) 689-6534 Laboratory Staffed for Questions and Results Daily, 24 Hrs./Day

TESTING PROFILES – May include one or more of the individual tests given below.

☐ Antibody Identification
☐ Hemolysis evaluation
☐ Suspected delayed hemolytic transfusion reaction
☐ Prenatal Antibody Identification (includes antibody titration, if indicated)
☐ Provision of compatible RBC units*
☐ Long term marrow transplant (HSCT) recipient follow-up
☐ Resolution of ABO discrepancy
☐ Other _____
☐ Provision of antigen negative RBC units*

*Submit "Request for Blood" to inventory number of units and processes required

INDIVIDUAL TESTS – If Profile has been checked above, do NOT check test below.

3103-00 ☐ ABO & Rh (D antigen typing)
3104-00 ☐ Indirect Antiglobulin Test (antibody screen)
3125-00 ☐ Direct Antiglobulin Test

3105-00 ☐ % ABO for HSCT
3103-00 ☐ Solid Organ Donor ABO & Rh (A1 lectin if group A) RF11
3137-00 ☐ Lectin Panel (T activation of rbcs)
3139-00 ☐ Donath-Landsteiner Test for PCH
3140-00 ☐ Thermal Amplitude

3115-00 ☐ Antibody Titer (other than anti-A or anti-B)
Specify antibody: _____
3115-00 ☐ Anti-A Titer for HSCT
3115-00 ☐ Anti-B Titer for HSCT
3115-00 ☐ ABO Incompatible Heart Transplant Titer (☐anti-A or ☐anti-B)
3115-00 ☐ ABO Incompatible Liver Transplant Titer (☐anti-A or ☐anti-B)
3115-00 ☐ UNOS Protocol Titer (anti-A or anti-B)

3117-00/3118-00 ☐ Sickle Cell Phenotype (Rh & K)
3117-00 ☐ Rh Phenotype (D, C, E, c antigen typing (e if indicated))
☐ Single Antigen Phenotype
3118-00 Specify antigen: _____
3136-00 ☐ Extended Patient Phenotype (7 or more antigens)
3127-00 ☐ Autoabsorption
3128-00 ☐ Alloadsorption
3129-00 ☐ Elution
3119-00 ☐ Screening of antigen-negative RBC units
Specify number of units: _____
3120-00 ☐ Screening of compatible RBC units
Specify number of units: _____
☐ Other _____

The above tests should be performed STAT*
☐ All ☐ Specify _____
*STAT testing will incur STAT Fee (3116-00 or 3059-00)
STAT orders will be given priority, but complex evaluations will take additional time.

PLEASE PRINT. Submit separate request and separate blood sample per laboratory.
NOTE: Information in RED must be completed.

Sample Drawn: DATE ____ / ____ / ____ TIME _____ am/pm

Sample Drawn By:

X _____ /X _____
Person drawing blood and reviewing patient ID *2nd person reviewing patient ID (If Required by facility policy)*

Specimen/Accession No.: _____

Physician or Authorized Person Order Test _____

Diagnosis/Purpose of Testing: _____

History / Comments / Special Instructions: _____

Form Completed By: _____

Name must match EXACTLY name on sample label.

Name on Sample *LAST*	*FIRST*	*M.I.*
Hospital Identification Number		
Hospital/Institution		
Social Security Number	*Sex (M/F)*	*Date of Birth (mm/dd/yr)*

Contact Person: _____
Name *Number*

INCLUDE PHONE NUMBER OR FAX NUMBER TO REPORT RESULTS AS SOON AS AVAILABLE OR FOR STAT TESTING

If results are needed as soon as available, PHONE ☐ or FAX ☐
_____ at ( ) _____
Name *Number*

SEND REPORT TO:
Name _____
Street _____
City, State, Zip _____

SEND BILL TO (if different than above):
Name _____
Street _____
City, State, Zip _____

TRANSFUSION SERVICES

Compatibility Testing Laboratory (CTL)
Immunohematology Reference Laboratory (IRL)

Completion of the Request for Testing (RFT):
In addition to the specimen identification, the RFT must contain all of the information that is printed in red on the RFT: draw date/time, physician or authorized person ordering test, to whom to send the report. Identifying a contact person is required to facilitate timely resolution of discrepancies and questions.

If Blood Services (Regional) Hospital requesting Immunohematology consultation: Send Immunohematology Consultation Request with Request for Testing. If patient has been transfused within the last 30 days, and submitting for antibody identification, send pre- and post-transfusion samples.

Sample Labeling: All samples must be properly labeled and information must agree with the identification on the RFT.

- If a specimen is identified by name, there must be a numeric identifier which may include Hospital number, SS#, or other coded identifier.
- If only a numeric identifier is used (with no name), the number must be a Hospital number, SS#, or coded identifier. A birthdate is not acceptable in this circumstance.
- A draw date should be on the sample but the sample will still be accepted if the draw information is on the RFT.

Sample Requirements: Sample requirements for some tests are given below; please call the laboratory for samples required for other tests. Complete information on sample requirements, CPT codes, test description, scheduling and reporting can be found at http://www.bloodworksnw.org/lab_redcell/tests.htm. Samples containing silica gel are not accepted for testing.

Patients >5 years old: All tests require one full 7 ml EDTA sample as the minimum amount.

Exceptions/comments:

- Prenatal Antibody Identification, Suspected Delayed Hemolytic Transfusion Reaction, and Hemolysis Evaluation: 2 full 7 ml EDTA tubes.
- Antibody Identification: 20 ml EDTA tube or 20 ml clotted sample.
- Donath-Landsteiner Test & Thermal Amplitude Test: 10 ml clotted sample drawn and maintained at 37 degrees C. until serum is separated from clot. NOTE: We accept EDTA sample for Thermal Amplitude Test, sample drawn and maintained at 37°C until the plasma is separated.
- Extended Postnatal Profile on Mother including Fetal Bleed Screen: postnatal samples should be drawn > 1 hour post delivery.

Patients between 1 and 5 years old: One full 3 ml EDTA sample as the minimum amount.

Patients 1 year old or less: Two full 0.5 ml EDTA microtainers (1.0 ml total) of peripheral blood is the minimum amount. For the Extended Postnatal Profile on baby, 6 – 7 ml cord blood is acceptable (EDTA is preferred).

Transporting Samples: Please notify the laboratory of shipping arrangements by phone (206-689-6534). All samples must be sent to Bloodworks in a sealed, leak-proof container marked with a biohazard sticker to comply with OSHA safety standards. Ship at ambient temperature unless instructed otherwise.

Testing Profile with defined individual tests:

Tests performed in Profiles:

3103-00 / 3104-00	**Prenatal Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00	**Potential Transplant Recipient Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00	**Potential Donor Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00 3145-00	**Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin.** ABO, Rh, antibody screen on mother. Antibody identification and fetal bleed screen if indicated.
3103-00 / 3104-00	**Extended Postnatal Profile (for Mother) no Fetal Bleed Screen:** ABO, Rh, antibody screen on mother. Antibody identification if indicated. Does not include fetal bleed screen.
3103-00 / 3125-00	**Extended Postnatal Profile (for Baby):** ABO, Rh, direct antiglobulin test. Antibody identification performed separately if indicated/requested.

TO REORDER FORMS CALL 425-656-3022

REQUEST FOR TESTING TRANSFUSION SERVICES

Bloodworks Northwest

921 Terry Avenue • Seattle, WA 98104-1256

BW Tech	BW ID / CL #

Time Received

See back of this form for sample requirements. Current test descriptions and CPT codes may be viewed at http://www.bloodworksnw.org/lab_redcell/tests.htm Shaded areas for BW use only.

COMPATIBILITY TESTING LABORATORY (CTL)

Laboratory Staffed for Questions and Results Daily, 24 Hrs./Day

Phone: Central (206) 689-6525 | Overlake (425) 467-3374 | SKL (425) 656-7900 | Evergreen (425) 434-4949 | Children's (206) 987-5151

TESTING PROFILES – Battery of test in Profiles are listed on the back of this form.

3103-00/3104-00 ☐ Prenatal profile.
Date Antepartum RhIg issued _____

3103-00/3104-00 ☐ Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin
3145-00

3103-00/3104-00 ☐ Extended Postnatal Profile (for Mother) no Fetal Bleed Screen

3103-00/3125-00 ☐ Extended Postnatal Profile (for Baby)
Mother's name _____

3103-00/3104-00 ☐ Potential Donor Profile

3103-00/3104-00 ☐ Potential Transplant Recipient Profile

Immunohematology Reference Laboratory (IRL) Phone (206) 689-6534

Laboratory Staffed for Questions and Results Daily, 24 Hrs./Day

TESTING PROFILES – May include one or more of the individual tests given below.

☐ Antibody Identification
☐ Hemolysis evaluation
☐ Suspected delayed hemolytic transfusion reaction
☐ Prenatal Antibody Identification (includes antibody titration, if indicated)
☐ Provision of compatible RBC units*
☐ Long term marrow transplant (HSCT) recipient follow-up
☐ Resolution of ABO discrepancy
☐ Other ____
☐ Provision of antigen negative RBC units*

*Submit "Request for Blood" to inventory number of units and processes required

INDIVIDUAL TESTS – If Profile has been checked above, do NOT check test below.

3103-00 ☐ ABO & Rh (D antigen typing)
3104-00 ☐ Indirect Antiglobulin Test (antibody screen)
3125-00 ☐ Direct Antiglobulin Test

3105-00 ☐ % ABO for HSCT
3103-00 ☐ Solid Organ Donor ABO & Rh (A1 lectin if group A) RF11
3137-00 ☐ Lectin Panel (T activation of rbcs)
3139-00 ☐ Donath-Landsteiner Test for PCH
3140-00 ☐ Thermal Amplitude

3115-00 ☐ Antibody Titer (other than anti-A or anti-B)
Specify antibody: _____
3115-00 ☐ Anti-A Titer for HSCT
3115-00 ☐ Anti-B Titer for HSCT
3115-00 ☐ ABO Incompatible Heart Transplant Titer (anti-A or anti-B)
3115-00 ☐ ABO Incompatible Liver Transplant Titer (anti-A or anti-B)
3115-00 ☐ UNOS Protocol Titer (anti-A or anti-B)

3117-00/3118-00 ☐ Sickle Cell Phenotype (Rh & K)
3117-00 ☐ Rh Phenotype (D, C, E, c antigen typing (e if indicated))
☐ Single Antigen Phenotype
3118-00 Specify antigen: _____
3136-00 ☐ Extended Patient Phenotype (7 or more antigens)
3127-00 ☐ Autoabsorption
3128-00 ☐ Alloadsorption
3129-00 ☐ Elution
3119-00 ☐ Screening of antigen-negative RBC units
Specify number of units: _____
3120-00 ☐ Screening of compatible RBC units
Specify number of units: _____
☐ Other _____

The above tests should be performed STAT*
☐ All ☐ Specify _____
*STAT testing will incur STAT Fee (3116-00 or 3059-00)
STAT orders will be given priority, but complex evaluations will take additional time.

PLEASE PRINT. Submit separate request and separate blood sample per laboratory.
NOTE: Information in RED must be completed.

Sample Drawn: DATE ____ / ____ / ____ TIME _____ am/pm

Sample Drawn By:

X _____ /X _____
Person drawing blood and reviewing patient ID — *2nd person reviewing patient ID (If Required by facility policy)*

Specimen/Accession No.: _____

Physician or Authorized Person Order Test _____

Diagnosis/Purpose of Testing: _____

History / Comments / Special Instructions: _____

Form Completed By: _____

Name must match EXACTLY name on sample label.

Name on Sample *LAST*	*FIRST*	*M.I.*
Hospital Identification Number		
Hospital/Institution		
Social Security Number	*Sex (M/F)*	*Date of Birth (mm/dd/yr)*

Contact Person: _____
Name *Number*

INCLUDE PHONE NUMBER OR FAX NUMBER TO REPORT RESULTS AS SOON AS AVAILABLE OR FOR STAT TESTING

If results are needed as soon as available, PHONE ☐ or FAX ☐
_____ at ( ) _____
Name *Number*

SEND REPORT TO:
Name _____
Street _____
City, State, Zip _____

SEND BILL TO (if different than above):
Name _____
Street _____
City, State, Zip _____

TRANSFUSION SERVICES

Compatibility Testing Laboratory (CTL)
Immunohematology Reference Laboratory (IRL)

Completion of the Request for Testing (RFT):
In addition to the specimen identification, the RFT must contain all of the information that is printed in red on the RFT: draw date/time, physician or authorized person ordering test, to whom to send the report. Identifying a contact person is required to facilitate timely resolution of discrepancies and questions.

If Blood Services (Regional) Hospital requesting Immunohematology consultation: Send Immunohematology Consultation Request with Request for Testing. If patient has been transfused within the last 30 days, and submitting for antibody identification, send pre- and post-transfusion samples.

Sample Labeling: All samples must be properly labeled and information must agree with the identification on the RFT.

- If a specimen is identified by name, there must be a numeric identifier which may include Hospital number, SS#, or other coded identifier.
- If only a numeric identifier is used (with no name), the number must be a Hospital number, SS#, or coded identifier. A birthdate is not acceptable in this circumstance.
- A draw date should be on the sample but the sample will still be accepted if the draw information is on the RFT.

Sample Requirements: Sample requirements for some tests are given below; please call the laboratory for samples required for other tests. Complete information on sample requirements, CPT codes, test description, scheduling and reporting can be found at http://www.bloodworksnw.org/lab_redcell/tests.htm. Samples containing silica gel are not accepted for testing.

Patients >5 years old: All tests require one full 7 ml EDTA sample as the minimum amount.

Exceptions/comments:

- Prenatal Antibody Identification, Suspected Delayed Hemolytic Transfusion Reaction, and Hemolysis Evaluation: 2 full 7 ml EDTA tubes.
- Antibody Identification: 20 ml EDTA tube or 20 ml clotted sample.
- Donath-Landsteiner Test & Thermal Amplitude Test: 10 ml clotted sample drawn and maintained at 37 degrees C. until serum is separated from clot. NOTE: We accept EDTA sample for Thermal Amplitude Test, sample drawn and maintained at 37°C until the plasma is separated.
- Extended Postnatal Profile on Mother including Fetal Bleed Screen: postnatal samples should be drawn > 1 hour post delivery.

Patients between 1 and 5 years old: One full 3 ml EDTA sample as the minimum amount.

Patients 1 year old or less: Two full 0.5 ml EDTA microtainers (1.0 ml total) of peripheral blood is the minimum amount. For the Extended Postnatal Profile on baby, 6 – 7 ml cord blood is acceptable (EDTA is preferred).

Transporting Samples: Please notify the laboratory of shipping arrangements by phone (206-689-6534). All samples must be sent to Bloodworks in a sealed, leak-proof container marked with a biohazard sticker to comply with OSHA safety standards. Ship at ambient temperature unless instructed otherwise.

Testing Profile with defined individual tests:

Tests performed in Profiles:

3103-00 / 3104-00	**Prenatal Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00	**Potential Transplant Recipient Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00	**Potential Donor Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00 3145-00	**Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin.** ABO, Rh, antibody screen on mother. Antibody identification and fetal bleed screen if indicated.
3103-00 / 3104-00	**Extended Postnatal Profile (for Mother) no Fetal Bleed Screen:** ABO, Rh, antibody screen on mother. Antibody identification if indicated. Does not include fetal bleed screen.
3103-00 / 3125-00	**Extended Postnatal Profile (for Baby):** ABO, Rh, direct antiglobulin test. Antibody identification performed separately if indicated/requested.

TO REORDER FORMS CALL 425-656-3022

REQUEST FOR TESTING TRANSFUSION SERVICES

Bloodworks Northwest

921 Terry Avenue • Seattle, WA 98104-1256

BW Tech	BW ID / CL #

Time Received

See back of this form for sample requirements. Current test descriptions and CPT codes may be viewed at http://www.bloodworksnw.org/lab_redcell/tests.htm Shaded areas for BW use only.

COMPATIBILITY TESTING LABORATORY (CTL)

Laboratory Staffed for Questions and Results Daily, 24 Hrs./Day

Phone: Central (206) 689-6525 | Overlake (425) 467-3374 | SKL (425) 656-7900 | Evergreen (425) 434-4949 | Children's (206) 987-5151

TESTING PROFILES – Battery of test in Profiles are listed on the back of this form.

3103-00/3104-00 ☐ Prenatal profile.
Date Antepartum RhIg issued _____

3103-00/3104-00 ☐ Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin
3145-00

3103-00/3104-00 ☐ Extended Postnatal Profile (for Mother) no Fetal Bleed Screen

3103-00/3125-00 ☐ Extended Postnatal Profile (for Baby)
Mother's name _____

3103-00/3104-00 ☐ Potential Donor Profile

3103-00/3104-00 ☐ Potential Transplant Recipient Profile

Immunohematology Reference Laboratory (IRL) Phone (206) 689-6534

Laboratory Staffed for Questions and Results Daily, 24 Hrs./Day

TESTING PROFILES – May include one or more of the individual tests given below.

☐ Antibody Identification
☐ Hemolysis evaluation
☐ Suspected delayed hemolytic transfusion reaction
☐ Prenatal Antibody Identification (includes antibody titration, if indicated)
☐ Provision of compatible RBC units*
☐ Long term marrow transplant (HSCT) recipient follow-up
☐ Resolution of ABO discrepancy
☐ Other ____
☐ Provision of antigen negative RBC units*

*Submit "Request for Blood" to inventory number of units and processes required

INDIVIDUAL TESTS – If Profile has been checked above, do NOT check test below.

3103-00 ☐ ABO & Rh (D antigen typing)
3104-00 ☐ Indirect Antiglobulin Test (antibody screen)
3125-00 ☐ Direct Antiglobulin Test

3105-00 ☐ % ABO for HSCT
3103-00 ☐ Solid Organ Donor ABO & Rh (A1 lectin if group A) RF11
3137-00 ☐ Lectin Panel (T activation of rbcs)
3139-00 ☐ Donath-Landsteiner Test for PCH
3140-00 ☐ Thermal Amplitude

3115-00 ☐ Antibody Titer (other than anti-A or anti-B)
Specify antibody: _____
3115-00 ☐ Anti-A Titer for HSCT
3115-00 ☐ Anti-B Titer for HSCT
3115-00 ☐ ABO Incompatible Heart Transplant Titer (anti-A or anti-B)
3115-00 ☐ ABO Incompatible Liver Transplant Titer (anti-A or anti-B)
3115-00 ☐ UNOS Protocol Titer (anti-A or anti-B)

3117-00/3118-00 ☐ Sickle Cell Phenotype (Rh & K)
3117-00 ☐ Rh Phenotype (D, C, E, c antigen typing (e if indicated))
☐ Single Antigen Phenotype
3118-00 Specify antigen: _____
3136-00 ☐ Extended Patient Phenotype (7 or more antigens)
3127-00 ☐ Autoabsorption
3128-00 ☐ Alloadsorption
3129-00 ☐ Elution
3119-00 ☐ Screening of antigen-negative RBC units
Specify number of units: _____
3120-00 ☐ Screening of compatible RBC units
Specify number of units: _____
☐ Other _____

The above tests should be performed STAT*
☐ All ☐ Specify _____
*STAT testing will incur STAT Fee (3116-00 or 3059-00)
STAT orders will be given priority, but complex evaluations will take additional time.

PLEASE PRINT. Submit separate request and separate blood sample per laboratory.
NOTE: Information in RED must be completed.

Sample Drawn: DATE ____ / ____ / ____ TIME _____ am/pm

Sample Drawn By:

X _____ /X _____
Person drawing blood and reviewing patient ID — *2nd person reviewing patient ID (If Required by facility policy)*

Specimen/Accession No.: _____

Physician or Authorized Person Order Test _____

Diagnosis/Purpose of Testing: _____

History / Comments / Special Instructions: _____

Form Completed By: _____

Name must match EXACTLY name on sample label.

Name on Sample *LAST*	*FIRST*	*M.I.*
Hospital Identification Number		
Hospital/Institution		
Social Security Number	*Sex (M/F)*	*Date of Birth (mm/dd/yr)*

Contact Person: _____
Name *Number*

INCLUDE PHONE NUMBER OR FAX NUMBER TO REPORT RESULTS AS SOON AS AVAILABLE OR FOR STAT TESTING

If results are needed as soon as available, PHONE ☐ or FAX ☐
_____ at ( ) _____
Name *Number*

SEND REPORT TO:
Name _____
Street _____
City, State, Zip _____

SEND BILL TO (if different than above):
Name _____
Street _____
City, State, Zip _____

TRANSFUSION SERVICES

Compatibility Testing Laboratory (CTL)
Immunohematology Reference Laboratory (IRL)

Completion of the Request for Testing (RFT):
In addition to the specimen identification, the RFT must contain all of the information that is printed in red on the RFT: draw date/time, physician or authorized person ordering test, to whom to send the report. Identifying a contact person is required to facilitate timely resolution of discrepancies and questions.

If Blood Services (Regional) Hospital requesting Immunohematology consultation: Send Immunohematology Consultation Request with Request for Testing. If patient has been transfused within the last 30 days, and submitting for antibody identification, send pre- and post-transfusion samples.

Sample Labeling: All samples must be properly labeled and information must agree with the identification on the RFT.

- If a specimen is identified by name, there must be a numeric identifier which may include Hospital number, SS#, or other coded identifier.
- If only a numeric identifier is used (with no name), the number must be a Hospital number, SS#, or coded identifier. A birthdate is not acceptable in this circumstance.
- A draw date should be on the sample but the sample will still be accepted if the draw information is on the RFT.

Sample Requirements: Sample requirements for some tests are given below; please call the laboratory for samples required for other tests. Complete information on sample requirements, CPT codes, test description, scheduling and reporting can be found at http://www.bloodworksnw.org/lab_redcell/tests.htm. Samples containing silica gel are not accepted for testing.

Patients >5 years old: All tests require one full 7 ml EDTA sample as the minimum amount.

Exceptions/comments:

- Prenatal Antibody Identification, Suspected Delayed Hemolytic Transfusion Reaction, and Hemolysis Evaluation: 2 full 7 ml EDTA tubes.
- Antibody Identification: 20 ml EDTA tube or 20 ml clotted sample.
- Donath-Landsteiner Test & Thermal Amplitude Test: 10 ml clotted sample drawn and maintained at 37 degrees C. until serum is separated from clot. NOTE: We accept EDTA sample for Thermal Amplitude Test, sample drawn and maintained at 37°C until the plasma is separated.
- Extended Postnatal Profile on Mother including Fetal Bleed Screen: postnatal samples should be drawn > 1 hour post delivery.

Patients between 1 and 5 years old: One full 3 ml EDTA sample as the minimum amount.

Patients 1 year old or less: Two full 0.5 ml EDTA microtainers (1.0 ml total) of peripheral blood is the minimum amount. For the Extended Postnatal Profile on baby, 6 – 7 ml cord blood is acceptable (EDTA is preferred).

Transporting Samples: Please notify the laboratory of shipping arrangements by phone (206-689-6534). All samples must be sent to Bloodworks in a sealed, leak-proof container marked with a biohazard sticker to comply with OSHA safety standards. Ship at ambient temperature unless instructed otherwise.

Testing Profile with defined individual tests:

Tests performed in Profiles:

3103-00 / 3104-00	**Prenatal Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00	**Potential Transplant Recipient Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00	**Potential Donor Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
3103-00 / 3104-00 3145-00	**Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin.** ABO, Rh, antibody screen on mother. Antibody identification and fetal bleed screen if indicated.
3103-00 / 3104-00	**Extended Postnatal Profile (for Mother) no Fetal Bleed Screen:** ABO, Rh, antibody screen on mother. Antibody identification if indicated. Does not include fetal bleed screen.
3103-00 / 3125-00	**Extended Postnatal Profile (for Baby):** ABO, Rh, direct antiglobulin test. Antibody identification performed separately if indicated/requested.