(CBS use only - Trace Line #)

CANADIAN BLOOD SERVICES- SASKATCHEWAN CENTRE
2571 Broad Street Regina, Sk. S4P 3B4

REQUEST FOR PERINATAL TESTING

Note: All information must be complete and legible for testing to be performed.

Last Name _____

First Name _____

PHN _____ DOB _____
YYYY/MM/DD

Unique ID# _____

SPECIMEN MUST BE DRAWN PRIOR TO INJECTION OF RH IMMUNE GLOBULIN

FAX REPORT TO:

Physician _____
(Initial) (Last Name)

Clinic _____

Address _____

City _____ Postal Code _____

Fax Number _____ Phone _____

Copy: (if applicable)

Physician _____
(Initial) (Last Name)

Address _____

City _____ Postal Code _____

Fax Number _____ Phone _____

Specimen Type:

☐ First Visit ☐ Father **(complete mother's information)**

☐ 26 – 28 Weeks ☐ Cord **(complete mother's information)**

☐ Fertility ☐ Other_____

NOTE: Mother's information must be complete when submitting Father/Cord specimen

Mother's Name _____
Last First

Mother's PHN _____

Mother's Expected Delivery Date _____
YYYY/MM/DD

Expected Date of Delivery _____
YYYY MM DD

Hospital for Delivery _____

Gravida (G) _____ Para (P) _____

Significant antibodies present? _____

Transfusion: ☐ No ☐ Yes Date _____

RhIg Administered ☐ No ☐ Yes Date _____

Specimen collected before RhIg injection ☐ No ☐ Yes

PHLEBOTOMIST: **Signature** _____

Collection Date _____**Time:**_____
YYYY/MM/DD

Collection Procedure **(Specimens not collected at Canadian Blood Services)**	Step	Responsibility of Phlebotomist
	1	**Label specimens with:** • Patient's last name, first name • PHN (or other unique ID number) • Date of collection **Ensure information on specimens EXACTLY matches information on requisition.**
	2	**Collection requirements:** 2 X 5 ml EDTA (lavender top)
	3	**Phlebotomist must complete the requisition by:** • Signing his/her name • Recording the date of collection

For Test Results: Phone 1-604-707-3527 Canadian Blood Services, Diagnostic Services, Vancouver Centre
Fax 1-604-874-6582