PATIENT REQUEST FOR ANTI-IgA TESTING

Canadian Blood Services
Société canadienne du sang

PART A: PATIENT INFORMATION

Surname:	Given Name:	Gender: M ☐ F ☐	DOB: ______ (yyyy/mm/dd)
Patient Identification Number:	Date Collected: ______ (yyyy/mm/dd)		

PART B: REASON FOR REQUEST/CONTACT INFORMATION

REASON FOR REQUEST:	Tests to be Performed:	
1. Transfusion Reaction: ☐ Anaphylactic ☐ Other ______ 2. Patient Requires Transfusion → Date Required: ______ ☐ Known Low or IgA deficient (blood component therapy or plasma protein product therapy) IgA level, if known ______ mg/dL	Anti-IgA	Hospital: ______ City: ______ Ordering Physician: ______ Contact Phone Number: ______ Fax Results To: ______

PART C: SAMPLE REQUIREMENTS

Sample required: Minimum 2 mL separated SERUM. Wrap sample caps with parafilm.

Label sample with the following: Name, ID Number, Collection Date, Date of Birth

Sample MUST be sent FROZEN with DRY ICE to local Canadian Blood Services Site.

Sample Prepared by: ______ Date: ______ (yyyy-mm-dd) Package Date: ______ (yyyy-mm-dd)

Canadian Blood Services Site:

Sample Packed by (Initials/date) : ______

Canadian Blood Services Site Medical Officer/Designate Review ☐ N/A

Initials ______ Date: ______

PART D: FOR BRAMPTON USE ONLY

ALIQUOTTING ☐ N/A		
Prepared by (Initials/date)	**Sample Aliquotted by** (Initials/date)	**Verified by** (Initials/date)