Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti.
Client # required

Person Completing Requisition	
Institution	Client #
Dept	Physician
Address	
City	ST ZIP
Phone (Lab)	Phone (Physician)

WISCONSIN IMMUNOHEMATOLOGY REFERENCE LAB
Phone 800-245-3117 x6205
Fax (414) 937-6461

Patient/Sample Name	Last		First		MI		
MR #		Accession #		**SSN**	- -		
DOB	/ /	Gender	☐ M ☐ F	Ethnicity	☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other		
Specimen Type	☐ EDTA/ Plasma ☐ Clot tube/Serum ☐ Other _____				Draw Date	Draw Time	
Fetal Specimen Type	☐ Amniotic Fluid ☐ Cultured Amniocytes ☐ CVS ☐ Cultured CVS ☐ Fetal Blood ☐ Other _____				/ /	:	

Special Reporting Requests:	**PO#:**	**Phleb ID:**

Medicare

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? **Yes ☐** **No ☐**

If yes, please complete our beneficiary form located at www.versiti.org/medical-professionals/products-services/requisitions and submit with this requisition.

Preliminary Results will be faxed to: _____ Results needed by (Date): _____

CLINICAL HISTORY: Diagnosis: _____ Hgb/Hct: _____

Indication for Transfusion: _____ Total Number of Pregnancies: _____ (including miscarriages and abortions)

Known Antibodies: _____

Prior Transfusions: ☐ Yes ☐ No Patient Status: ☐ Inpatient ☐ Outpatient

Most recent date transfused: _____ # Units Transfused: _____ ABO/Rh of units: _____

SEROLOGY

PLEASE ENCLOSE A COPY OF YOUR ABO/Rh, DAT, ANTIBODY SCREEN AND PANEL RESULTS

☐ Antibody Identification **(3060)** ☐ Antibody Titration **(3080)** ☐ DAT Negative Workup **(3111)** ☐ Donath Landsteiner

☐ Thermal Amplitude ☐ Other (please specify) **(3112)** _____

☐ Drug-Dependent RBC Antibody Study **(3110)** – Drug: _____

Please complete MEDICATION section on back of form (send >500 mg of suspected drug. Do not reconstitute.)

☐ Crossmatch Problem (IRL to crossmatch units) **(3050)** **Patient ID # used for transfusion:** _____

Number of units needed: Leuko-reduced RBC_____ ☐ CMV Neg ☐ Irradiate ☐ Other_____

PRENATAL (Fetal/Paternal) GENOTYPING			**MOLECULAR**
Maternal Blood for MCC must be submitted with fetal sample			☐ **Weak RhD Analysis (3040)**
Maternal Antibody(ies)			☐ **Partial RhD Analysis (3240)**
Paternal Name:		**DOB:**	☐ **Red Cell Genotyping Panel (44 Antigens) (3530)**
Paternal Blood (Recommended) Paternal Type (if known): _____ ☐ **N/A**			**Comments:**
☐ **RHD (3872)**	☐ **M/N (3864)**	☐ **Js(a)/Js(b) (3858)**	
☐ **K/k (3854)**	☐ **Fy(a)/Fy(b) (3860)**	☐ **Lu(a)/Lu(b) (3868)**	
☐ **C/c (3850)**	☐ **Jk(a)/Jk(b) (3862)**	☐ **Kp(a)/Kp(b) (3856)**	
☐ **E/e (3852)**	☐ **S/s (3866)**	☐ **Do(a)/Do(b) (3870)**	
☐ **RhD Zygosity (Paternal Only) (3874)**			

Versiti Use Only	
_____EDTA _____Clot _____Amnio _____CVS _____Other _____	Opened By _____ Evaluated By _____ Reviewed By _____ Labeled By _____

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All samples must include sample identification clearly marked on **each** specimen container. Proper identification includes full name of individual, date obtained, hospital and/or patient identification number and the identification of the individual obtaining the specimen. Federal regulations mandate that a completed laboratory requisition form accompany each sample. Blood samples must be packaged to comply with requirements of mail or overnight courier service, if used.

Shipping address: Versiti Wisconsin - Immunohematology Reference Laboratory
638 N. 18th Street
Milwaukee, WI 53233
Phone: (414) 937-6205

Recommended tubes for collection -- Do not use tubes that contain a silicone separator gel:
Plain red top vacutainers for clotted (serum) samples -- Lavender/Pink top vacutainer with EDTA anticoagulant

SPECIMEN REQUIREMENTS	
SUSPECTED SEROLOGIC PROBLEM	**REQUESTED AMOUNT**
Warm Autoimmune Hemolytic Anemia – IAT Positive with all panel cells tested and a positive DAT (1+ - 4+) *For patients under 20 kg body weight, sample requirements will be adjusted depending on communication with patient's physician.	**No transfusion within the past 3 months:** 24mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top) **Transfused within the past 3 months:** 5mL EDTA whole blood (lavender or pink top) AND 30mL clotted whole blood (red top)
ABO Antibody Titers	10mL EDTA whole blood (lavender or pink top) OR 10mL clotted whole blood (red top)
Crossmatch Problem Antibody Antibody Identification Confirmation Transfusion Reaction Antibody Titration	5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top)
DAT Negative Autoimmune Hemolytic Anemia Study	10mL EDTA whole blood (lavender or pink top) AND 21 mL clotted whole blood (red top)
Thermal Amplitude or Donath-Landsteiner Test	5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top) tubes **prewarmed and maintained at 37°C during clotting and serum separated immediately**
Hemolytic Disease of the Newborn	Child – Cord blood sample (if available) Mother – 5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top)
Drug-Dependent RBC Antibody Study (complete the medication history listed below)	5mL EDTA whole blood (lavender or pink top) AND 21mL clotted whole blood (red top) tubes AND **include a sample of each suspected drug**

MOLECULAR TESTS	REQUESTED AMOUNT
Rh D Discrepancy Analysis / Partial D Analysis	5mL EDTA whole blood (lavender or pink top)
Red Cell Genotyping Panel (44 Antigens)	5mL EDTA whole blood (lavender or pink top)
Prenatal Genotyping	**FETAL**: 7-15 mL Amniotic Fluid or 5-10 mg CVS **Backup Culture** (highly recommended)**:** Two (2) T25 flasks Cultured Amniocytes or CVS (2 × 10^6 minimum) **MATERNAL**: 3-5 mL EDTA whole blood for MCC (lavender top). **PATERNAL**: 3-5 mL EDTA whole blood

MEDICATION --- List all medications, prescription and non-prescription, taken in the past 30 days (include: aspirin, anticoagulants, oral contraceptives, or antibiotics)

Medication	Dose	Date Begun	Last Taken