**MAYO CLINIC HEALTH SYSTEM**
**FRANCISCAN HEALTHCARE TRANSFUSION SERVICE**

# ANTIBODY WORKUP REQUEST INFORMATION FORM

## COMPLETE AND SUBMIT WITH SAMPLE

**Also, please include a copy of your antibody screen reactions and results if performed. Sample minimum is 1 (10 mL) pink EDTA tube**

**Patient's Name: _____** **Referring Hospital: _____**

**Date of Birth: _____** **Race: _____**

**Physician: _____** **Collection Date: _____**

**Patient ABO/RH: _____** **DAT: _____**

**Clinical History**

**Diagnosis (if known):**
_____

**Current Medications (if known):**
_____

**Date of Rhogam (if known):_____**

**Known antibodies: _____**

**Previous Pregnancies (including miscarriages and abortions): ___Y/N_____**

**Prior Transfusions: Yes or No Dates: _____**

**Current Hbg: _____ Comments: _____**

**Work-up Requested**

**Need by: _____**

**Antibody Identification _____**

**Antigen Typing Patient _____**

**Antigen Typing Units _____ How many? _____**
**Segments sent: _____**

**Tech: _____ Date: _____**