Guidance Notes: 3A

NHS Blood and Transplant

H&I Diagnostic laboratory test request guidance information

USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS

A **separate request** must accompany **every sample** including for each family member, sample date & type. Please ensure **samples tubes** have **three points of ID** that are **as recorded on the test request** and that they are **signed and dated**. Ensure you have identified the **referring hospital clearly**.
Tests can be delayed or not carried out when necessary information is not supplied.
Refer to the reverse of the form for more information.

Please do not detach sample bag

Enter PATIENT DETAILS
THREE points of I.D.

Fore and surname = I.D.1
DoB = I.D.2
NHS No. = I.D.3

NHS No. is essential where available, if not available another unique identifier must be supplied

Enter FULL HOSPITAL NAME
Enter ODS CODE if known

PRINT contact details

SIGN & DATE the request

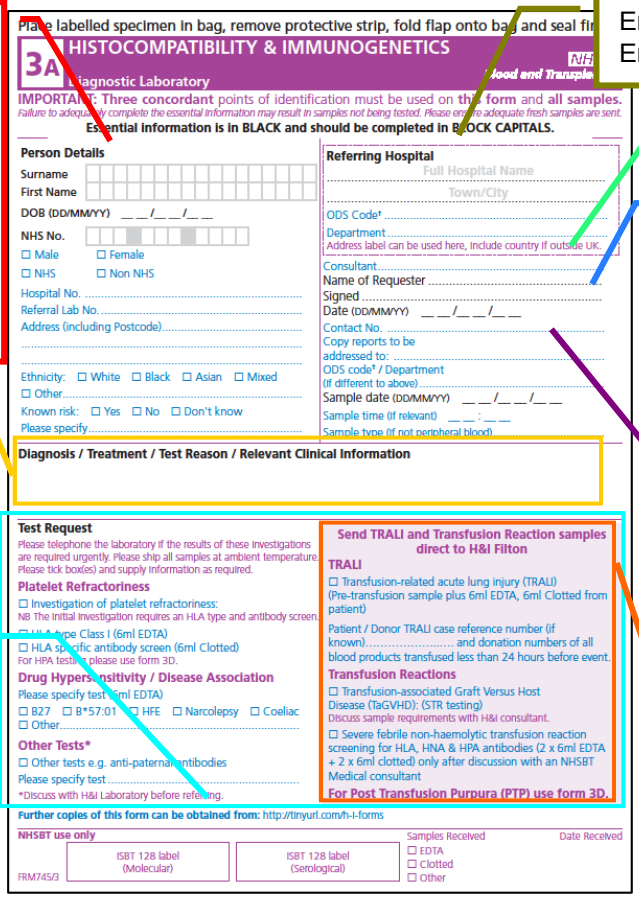
Reports will only be sent to contacts listed here

Write telephone numbers clearly, direct dial please

Enter relevant clinical details here. e.g. Platelet counts for platelet refractoriness.

Please ensure correct test boxes are ticked and information supplied

Send TRALI and Transfusion Reaction samples direct to H&I Filton



This information document, test request forms and more information about NHSBT H&I services can be found on the NHSBT hospital and science website at http://tinyurl.com/h-i-forms

Histocompatibility and Immunogenetics Laboratory		Telephone	FAX
Birmingham	Vincent Drive, Edgbaston, Birmingham, B15 2SG	0121 278 4179	0121 278 4110
Filton (Bristol)	500 North Bristol Park, Northway, Filton, Bristol, BS34 7QH	0117 912 5733	0117 912 5731
Colindale	Charcot Road, Colindale, London, NW9 5BG	020 8957 2923	020 8957 2973
Newcastle	Holland Drive, Barrack Road, Newcastle upon Tyne, NE2 4NQ	0191 202 4410	0191 202 4564
Sheffield	Longley Lane, Sheffield, S5 7JN	0114 358 4839	0114 358 4850
Tooting	Cranmer Terrace, London, SW17 ORB	020 3123 8347	020 3123 8457

Guidance Notes: 3B

NHS Blood and Transplant

H&I Organ Transplant Recipients and Donors Test Request Guidance Information

USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS

A **separate request** must accompany **every sample** including for each family member, sample date & type.

Please ensure **samples tubes** have **three points of ID** that are **repeated on the test request** and that they are both **signed and dated**.
Ensure sufficient sample is present, refer to the reverse of the form for more information

Please do not detach sample bag

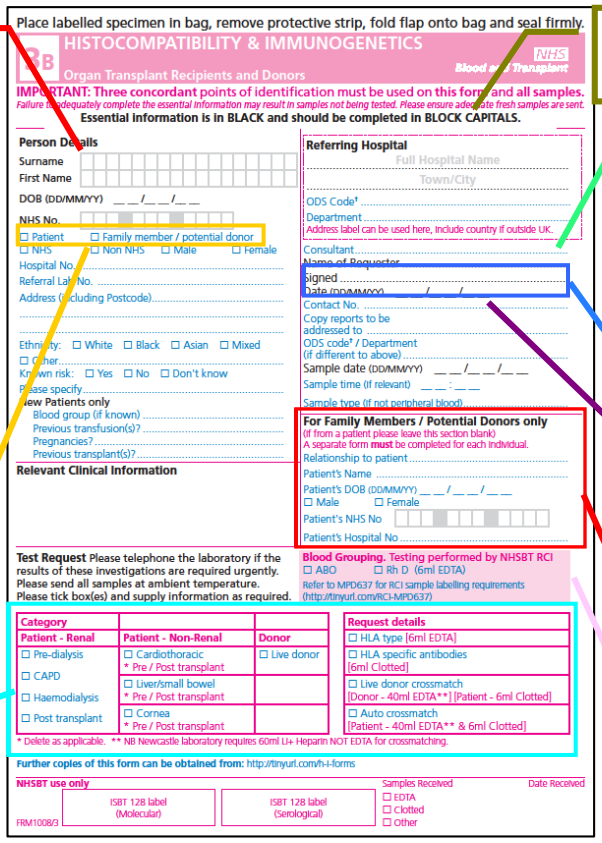
Enter PATIENT DETAILS
THREE points of I.D.

Fore and surname = I.D.1
DoB = I.D.2
NHS No. = I.D.3

NHS No. is essential where available, if not available another unique identifier must be supplied

Indicate if person is a **patient or donor**

Please ensure correct test boxes are ticked



Enter FULL HOSPITAL NAME
Enter ODS CODE if known

PRINT contact details

Reports will only be sent to contacts listed here

SIGN & DATE the request

Write telephone numbers clearly, direct dial numbers are preferred

if potential donor complete the details here

If blood grouping is needed request it here

This information document, test request forms and more information about NHSBT H&I services can be found on the NHSBT hospital and science website at http://tinyurl.com/h-i-forms

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Birmingham	Vincent Drive, Edgbaston, Birmingham, B15 2SG	0121 278 4179	0121 278 4110
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Newcastle	Holland Drive, Barrack Road, Newcastle upon Tyne, NE2 4NQ	0191 202 4410	0191 202 4564
Sheffield	Longley Lane, Sheffield, S5 7JN	0114 358 4839	0114 358 4850
Tooting	Cranmer Terrace, London, SW17 ORB	020 3123 8347	020 3123 8457

Guidance Notes: 3C

NHS Blood and Transplant

H&I HSCT patient and donor test request guidance information

USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS

A **separate request** must accompany **every sample** including for each family member, sample date & type.
Please ensure **samples tubes** have **three points of ID** that are **as recorded on the test request form** and that they are **signed and dated**.

Ensure you have identified the **referring hospital clearly**.
Tests can be delayed or not carried out when necessary information is not supplied.
Refer to the reverse of the form for more information.

Please do not detach sample bag

Enter PATIENT DETAILS
THREE points of I.D.

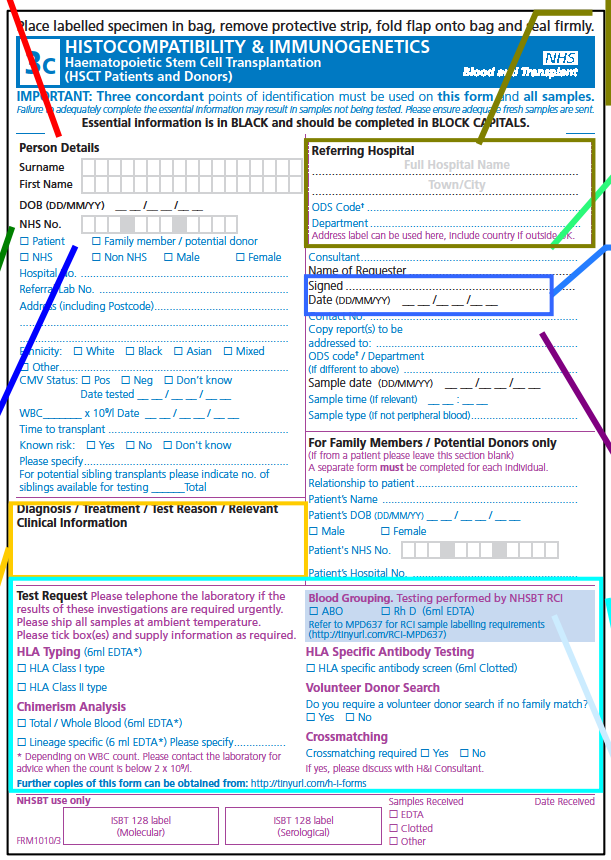
Fore and surname = I.D.1
DoB = I.D.2
NHS No. = I.D.3

NHS No. is essential where available, if not available another unique identifier must be supplied

Use of NHS NUMBER is mandated by Department of Health

Indicate if person is a **patient or donor**

Enter relevant clinical details here


Place labelled specimen in bag, remove protective strip, fold flap onto bag and seal firmly.

HISTOCOMPATIBILITY & IMMUNOGENETICS
Haematopoietic Stem Cell Transplantation (HSCT Patients and Donors)

IMPORTANT: Three concordant points of identification must be used on this form and all samples.
Failure to adequately complete the essential information may result in samples not being tested. Please ensure adequate fresh samples are sent.
Essential information is in BLACK and should be completed in BLOCK CAPITALS.

Person Details
Surname
First Name
DOB (DD/MM/YY) __ __/__ __/__ __
NHS No.
☐ Patient ☐ Family member / potential donor
☐ NHS ☐ Non NHS ☐ Male ☐ Female
Hospital No.
Referral Lab No.
Address (including Postcode)
Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Mixed ☐ Other
CMV Status: ☐ Pos ☐ Neg ☐ Don't know
Date tested __ __/__ __/__ __
WBC_____ x 10⁹/l Date __ __/__ __/__ __
Time to transplant
Known risk: ☐ Yes ☐ No ☐ Don't know
Please specify
For potential sibling transplants please indicate no. of siblings available for testing _____Total

Diagnosis / Treatment / Test Reason / Relevant Clinical Information

Referring Hospital
Full Hospital Name
Town/City
ODS Code*
Department
Address label can be used here, include country if outside UK.
Consultant
Name of Requester
Signed
Date (DD/MM/YY) __ __/__ __/__ __
Contact No.
Copy report(s) to be addressed to:
ODS code* / Department (if different to above)
Sample date (DD/MM/YY) __ __/__ __/__ __
Sample time (if relevant) __ __ : __ __
Sample type (if not peripheral blood)

For Family Members / Potential Donors only
(if from a patient please leave this section blank)
A separate form must be completed for each individual.
Relationship to patient
Patient's Name
Patient's DOB (DD/MM/YY) __ __/__ __/__ __
☐ Male ☐ Female
Patient's NHS No.
Patient's Hospital No.

Test Request Please telephone the laboratory if the results of these investigations are required urgently. Please ship all samples at ambient temperature. Please tick box(es) and supply information as required.
HLA Typing (6ml EDTA*)
☐ HLA Class I type
☐ HLA Class II type
Chimerism Analysis
☐ Total / Whole Blood (6ml EDTA*)
☐ Lineage specific (6 ml EDTA*) Please specify.....
* Depending on WBC count. Please contact the laboratory for advice when the count is below 2 x 10⁹/l.
Further copies of this form can be obtained from: http://tinyurl.com/h-i-forms

Blood Grouping. Testing performed by NHSBT RCI
☐ ABO ☐ Rh D (6ml EDTA)
Refer to MPD637 for RCI sample labelling requirements (http://tinyurl.com/RCI-MPD637)
HLA Specific Antibody Testing
☐ HLA specific antibody screen (6ml Clotted)
Volunteer Donor Search
Do you require a volunteer donor search if no family match?
☐ Yes ☐ No
Crossmatching
Crossmatching required ☐ Yes ☐ No
If yes, please discuss with H&I Consultant.

NHSBT use only
ISBT 128 label (Molecular)
ISBT 128 label (Serological)
Samples Received
☐ EDTA
☐ Clotted
☐ Other
Date Received
FRM1010/3

Enter
FULL HOSPITAL NAME
Enter ODS CODE if known

PRINT contact details

SIGN & DATE the request

Reports will only be sent to contacts listed here

Write telephone numbers clearly, direct dial please

Please ensure correct test boxes are ticked and information supplied

If blood grouping is needed request it here

This information document, test request forms and more information about NHSBT H&I services can be found on the NHSBT hospital and science website at http://tinyurl.com/h-i-forms

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Tooting	Cranmer Terrace, London, SW17 ORB	020 3123 8347	020 3123 8457

Guidance Notes: 3D

NHS Blood and Transplant

Platelet Immunology test request guidance information

USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS

Please ensure sample tubes have three points of ID that are repeated on the test request and that they are both signed and dated.

For AITP investigations of platelet membrane associated Immunoglobulin (PAIg) detection can only be carried out if the patient has not received platelet transfusions for 7-10 days or IvIg in the last 28 days, however serum platelet antibody detection can be undertaken.

Please send implicated drugs, and expected therapeutic levels, for drug related thrombocytopenia (not including heparin).

Please ensure samples tubes have three points of ID that are as recorded on the test request and that they are signed and dated.

3D forms and samples to be sent direct to H&I Filton

Please do not detach sample bag

Enter PATIENT DETAILS THREE points of I.D.

Fore and surname = I.D.1
DoB = I.D.2
NHS No. = I.D.3

NHS No. is essential where available, if not available another unique identifier must be supplied

Use of NHS NUMBER is mandated by Department of Health

Enter relevant clinical details here

Insert Mother's name if this is a NAIT partner's or child's sample

Enter FULL HOSPITAL NAME
Enter ODS CODE if known

PRINT contact details

Reports will only be sent to contacts listed here

SIGN & DATE the request

Write telephone numbers clearly, direct dial numbers are preferred

Please ensure correct test boxes are ticked

This information document, test request forms and more information about NHSBT H&I services can be found on the NHSBT hospital and science website at http://tinyurl.com/h-i-forms

Histocompatibility and Immunogenetics Laboratory		Telephone	FAX
Filton (Bristol)	500 North Bristol Park, Northway, Filton, Bristol, BS34 7QH	0117 921 7372	0117 912 5731

Guidance Notes: 3E

NHS Blood and Transplant

H&I Granulocyte Immunology test request guidance information

USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS

A **separate request** must accompany **every sample** including for each family member, sample date & type.
Ensure **samples tubes** have **three points of ID, as recorded on the test request.**

Tests can be delayed or not carried out when necessary information is not supplied.
Refer to the reverse of the form for more information.

Ensure you have identified the **referring hospital clearly**.
Tests can be delayed or not carried out when necessary information is not supplied.

3E forms and samples to be sent direct to H&I Filton

Please do not detach sample bag

Enter PATIENT DETAILS
THREE points of I.D.

Fore and surname = I.D.1
DoB = I.D.2
NHS No. = I.D.3

NHS No. is essential where available, if not available another unique identifier must be supplied

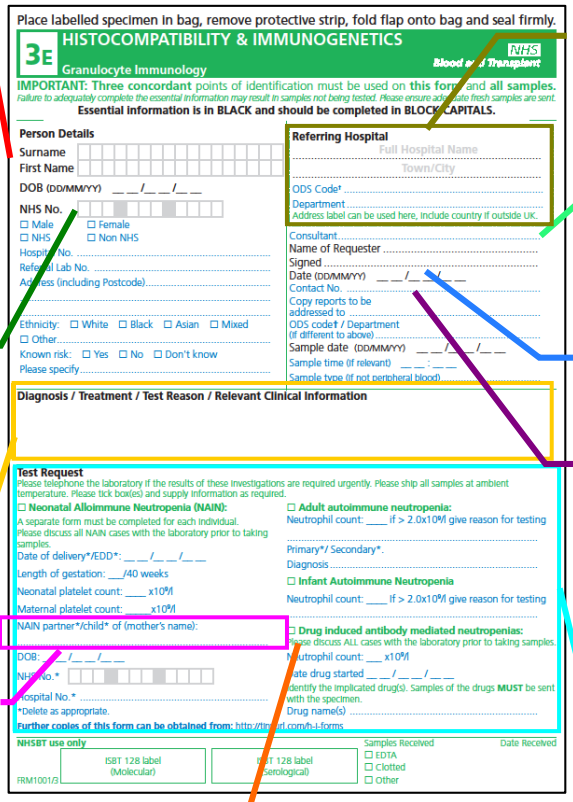
Use of NHS NUMBER is mandated by Department of Health

Enter relevant clinical details

Indicate if person is a patient, donor or relative

Insert Mother's name if this is a NAIN partner's or child's sample

For NAIN and Drug related cases please phone H&I Filton on 01179217372


Place labelled specimen in bag, remove protective strip, fold flap onto bag and seal firmly.

3E HISTOCOMPATIBILITY & IMMUNOGENETICS
Granulocyte Immunology

IMPORTANT: Three concordant points of identification must be used on this form and all samples.
Failure to adequately complete the essential information may result in samples not being tested. Please ensure adequate fresh samples are sent.
Essential information is in BLACK and should be completed in BLOCK CAPITALS.

Person Details
Surname
First Name
DOB (DD/MM/YY) __ __ /__ __ /__ __
NHS No.
☐ Male ☐ Female
☐ NHS ☐ Non NHS
Hospital No.
Referral Lab No.
Address (including Postcode)
Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Mixed ☐ Other
Known risk: ☐ Yes ☐ No ☐ Don't know
Please specify

Referring Hospital
Full Hospital Name
Town/City
ODS Code†
Department
Address label can be used here, include country if outside UK.
Consultant
Name of Requester
Signed
Date (DD/MM/YY) __ __ /__ __ /__ __
Contact No.
Copy reports to be addressed to
ODS code† / Department (if different to above)
Sample date (DD/MM/YY) __ __ /__ __ /__ __
Sample time (if relevant) __ __ : __ __
Sample type (if not peripheral blood)

Diagnosis / Treatment / Test Reason / Relevant Clinical Information

Test Request
Please telephone the laboratory if the results of these investigations are required urgently. Please ship all samples at ambient temperature. Please tick box(es) and supply information as required.
☐ Neonatal Alloimmune Neutropenia (NAIN):
A separate form must be completed for each individual.
Please discuss all NAIN cases with the laboratory prior to taking samples.
Date of delivery*/EDD*: __ __ /__ __ /__ __
Length of gestation: __/40 weeks
Neonatal platelet count: ____ x10⁹/l
Maternal platelet count: ____ x10⁹/l
NAIN partner*/child* of (mother's name):
DOB: __ __ /__ __ /__ __
NHS No.*
Hospital No.*
*Delete as appropriate.
Further copies of this form can be obtained from: http://tinyurl.com/h-i-forms

☐ Adult autoimmune neutropenia:
Neutrophil count: ____ if > 2.0x10⁹/l give reason for testing
Primary*/ Secondary*.
Diagnosis
☐ Infant Autoimmune Neutropenia
Neutrophil count: ____ If > 2.0x10⁹/l give reason for testing
☐ Drug induced antibody mediated neutropenias:
Please discuss ALL cases with the laboratory prior to taking samples.
Neutrophil count: ___ x10⁹/l
Date drug started __ __ /__ __ /__ __
Identify the implicated drug(s). Samples of the drugs MUST be sent with the specimen.
Drug name(s)

NHSBT use only
ISBT 128 label (Molecular)
ISBT 128 label (Serological)
Samples Received ☐ EDTA ☐ Clotted ☐ Other
Date Received
FRM1001/3

Enter FULL HOSPITAL NAME
Enter ODS CODE if known

PRINT contact details

Reports will only be sent to contacts listed here

SIGN & DATE the request

Write telephone numbers clearly, direct dial numbers are preferred

Please ensure correct test boxes are ticked and information supplied

This information document, test request forms and more information about NHSBT H&I services can be found on the NHSBT hospital and science website at http://tinyurl.com/h-i-forms

Histocompatibility and Immunogenetics Laboratory		Telephone	FAX
Filton (Bristol)	500 North Bristol Park, Northway, Filton, Bristol, BS34 7QH	0117 921 7372	0117 912 5731