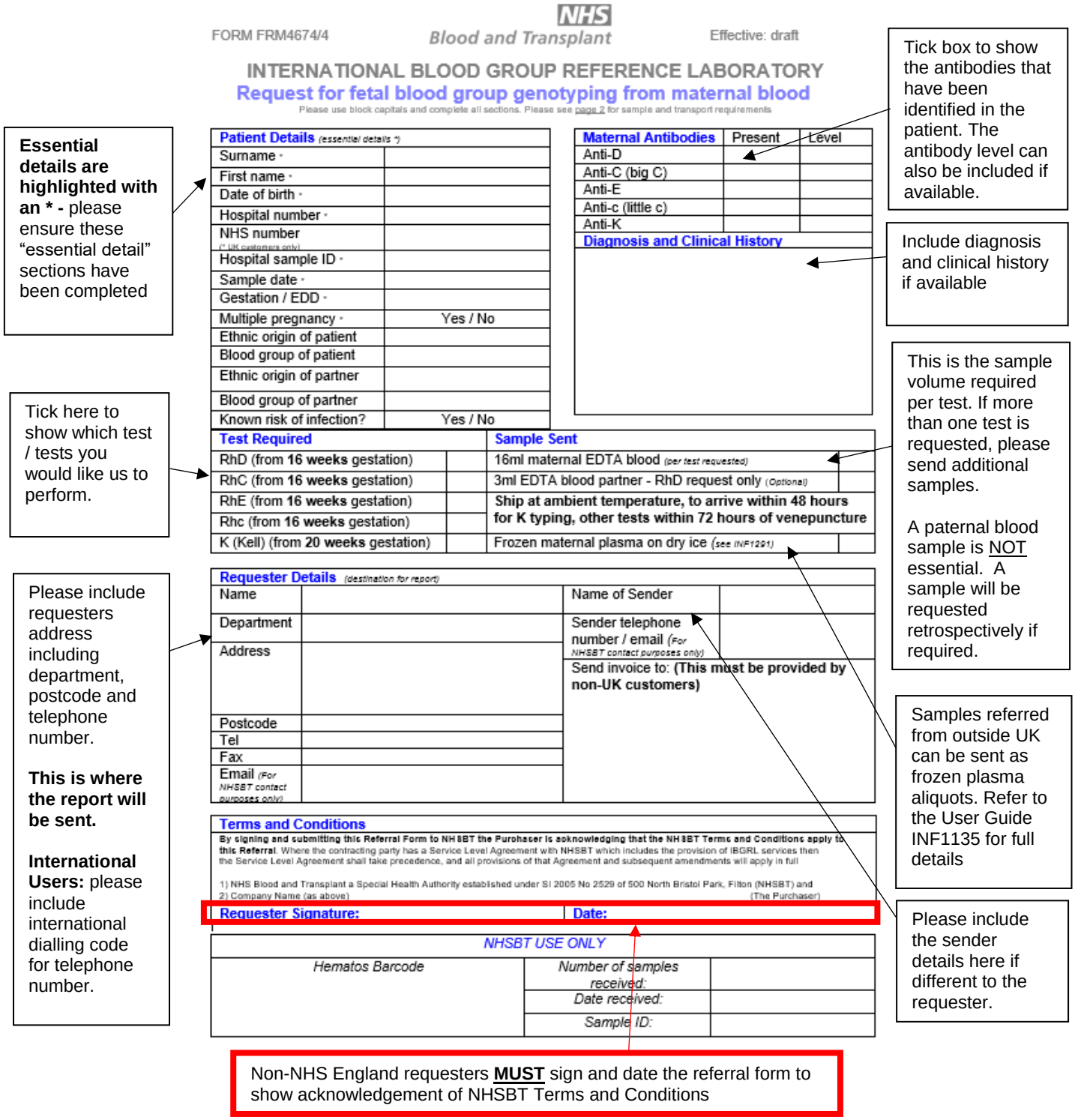
Guidance for completion of Molecular Diagnostics Request Form FRM4674

As a minimum, **three points** of **matching identification** (full name, DOB and unique identifier (hospital number / NHS number) **must** be included on both the samples and the accompanying form. The samples **must** be **signed** and **dated** by the person taking the blood**.** Please see User Guide (INF1135) for full details

Please note the request form is electronically editable



FORM FRM4674/4 — NHS Blood and Transplant — Effective: draft

INTERNATIONAL BLOOD GROUP REFERENCE LABORATORY

Request for fetal blood group genotyping from maternal blood

Please use block capitals and complete all sections. Please see page 2 for sample and transport requirements

Patient Details (essential details *)	
Surname *	
First name *	
Date of birth *	
Hospital number *	
NHS number (* UK customers only)	
Hospital sample ID *	
Sample date *	
Gestation / EDD *	
Multiple pregnancy *	Yes / No
Ethnic origin of patient	
Blood group of patient	
Ethnic origin of partner	
Blood group of partner	
Known risk of infection?	Yes / No

Maternal Antibodies	Present	Level
Anti-D		
Anti-C (big C)		
Anti-E		
Anti-c (little c)		
Anti-K		

Diagnosis and Clinical History

Test Required		Sample Sent	
RhD (from **16 weeks** gestation)		16ml maternal EDTA blood (per test requested)	
RhC (from **16 weeks** gestation)		3ml EDTA blood partner - RhD request only (Optional)	
RhE (from **16 weeks** gestation)		**Ship at ambient temperature, to arrive within 48 hours for K typing, other tests within 72 hours of venepuncture**	
Rhc (from **16 weeks** gestation)			
K (Kell) (from **20 weeks** gestation)		Frozen maternal plasma on dry ice (see INF1291)	

Requester Details (destination for report)			
Name		Name of Sender	
Department		Sender telephone number / email (For NHSBT contact purposes only)	
Address		Send invoice to: **(This must be provided by non-UK customers)**	
Postcode			
Tel			
Fax			
Email (For NHSBT contact purposes only)			

Terms and Conditions

By signing and submitting this Referral Form to NHSBT the Purchaser is acknowledging that the NHSBT Terms and Conditions apply to this Referral. Where the contracting party has a Service Level Agreement with NHSBT which includes the provision of IBGRL services then the Service Level Agreement shall take precedence, and all provisions of that Agreement and subsequent amendments will apply in full

1) NHS Blood and Transplant a Special Health Authority established under SI 2005 No 2529 of 500 North Bristol Park, Filton (NHSBT) and
2) Company Name (as above) (The Purchaser)

Requester Signature: **Date:**

NHSBT USE ONLY		
Hematos Barcode	Number of samples received:	
	Date received:	
	Sample ID:	

Essential details are highlighted with an * - please ensure these "essential detail" sections have been completed

Tick box to show the antibodies that have been identified in the patient. The antibody level can also be included if available.

Include diagnosis and clinical history if available

Tick here to show which test / tests you would like us to perform.

This is the sample volume required per test. If more than one test is requested, please send additional samples.

A paternal blood sample is NOT essential. A sample will be requested retrospectively if required.

Please include requesters address including department, postcode and telephone number.

This is where the report will be sent.

International Users: please include international dialling code for telephone number.

Samples referred from outside UK can be sent as frozen plasma aliquots. Refer to the User Guide INF1135 for full details

Please include the sender details here if different to the requester.

Non-NHS England requesters **MUST** sign and date the referral form to show acknowledgement of NHSBT Terms and Conditions