

A minimum of three matching points of ID are required on both the sample and the accompanying form. See the Fetal *RHD* screening user guide (INF1259) for full sample and request form requirements

**Request for fetal *RHD* Screen**

Cell-free fetal DNA from maternal blood
**Blood and Transplant**

This form is only to be used for RhD negative pregnant women.  
 Please **DO NOT USE** this form for samples from women who have anti-D (or -G) antibodies as samples will be rejected. Consult your Fetal Maternal Unit for referrals from women with anti-D (or -G) as a different form and sample volume is required.  
 At least three points of matching identification must be used on form and sample tubes

**Mother's Details:**

NHS No. \_\_\_\_\_ or\* Hospital No. \_\_\_\_\_  
\* (if NHS No. is not known). Please ensure that the numbers are the same on this form and the sample tube  
 i.e. NHS No. on both form and sample and/or Hospital No. on both form and sample

Surname \_\_\_\_\_  
 First name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DOB \_\_\_\_\_ EDD from dating scan\* \_\_\_\_\_  
\*Please arrange a dating scan, if not already performed, before taking blood sample

Please provide 6ml EDTA blood sample from the mother (store at room temperature)

Date of sample taken \_\_\_\_\_ Name of person taking sample \_\_\_\_\_

**Hospital and Requester Details:**

Hospital name (do not abbreviate) \_\_\_\_\_ Hospital NHS Code\* \_\_\_\_\_  
\*ODS code (Formerly NACS code)

Sender's name and address  Telephone: Email:	For Hospital Laboratory use  Date received:
<b>SEND SAMPLE WITH THIS FORM TO THE PATHOLOGY LABORATORY</b> <b>Instructions for Laboratory Reception</b> Follow Hospital Trust SOP. See sample labelling and transport instructions on the reverse of this form.	
For NHSBT use  Date received:	

FRM5197/3 Effective: 01/01/2021 2021450 MI1534.4

An NHS number is preferred for fetal *RHD* screening, if it is not available a hospital number may be used.

An estimated date of delivery (EDD) is essential for fetal *RHD* screening for identification of the pregnancy. EDD **must** be determined by **scan** before taking a sample. Number of weeks' gestation is not sufficient.

Date on sample submitted with this form for investigation. **Must** include year, e.g. 01/02/21, not just 01/02.

Use the 5 digit code. It is variously known as NHSIA/NACS or ODS code. (It is not the 4 character hospital code).

The **full** hospital name **must** be included. Please do not abbreviate. The hospital name and code determine where the report will be sent.

Place your hospital specimen barcode in this box if you need the number on the report. Do not place on the sample tube.