

INF1343/3 – Guidance for completion of Molecular Diagnostics Request Form FRM4674



Blood and Transplant

Copy No:

Effective date: 28/01/2022

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

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 *)		Maternal Antibodies		Present	Level
Surname *		Anti-D			
First name *		Anti-C (big C)			
Date of birth *		Anti-E			
Hospital number *		Anti-c (little c)			
NHS number (* UK customers only)		Anti-K			
Hospital sample ID *		Diagnosis and Clinical History			
Sample date *		<div style="border: 1px solid black; height: 100px;"></div>			
Gestation / EDD *					
Multiple pregnancy *	Yes <input type="checkbox"/> / No <input type="checkbox"/>				
Ethnic origin of patient					
Blood group of patient					
Ethnic origin of partner					
Blood group of partner					
Known risk of infection?	Yes <input type="checkbox"/> / No <input type="checkbox"/>				
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 INF120)			
Requester Details (destination for report) DO NOT USE ABBREVIATIONS					
Full hospital name		Name of Requester (for the report)			
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					
Our investigations require testing of an individual's DNA, and storage for possible testing or quality assurance purposes in the future. All genetic testing requires informed consent, and it is the responsibility of the requester to ensure this is obtained. NHSBT will assume that consent has been obtained prior to referral to our laboratories. 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 2006 No 2529 of 500 North Bristol Park, Filton ("NHSBT"); and					
Requester Signature:		Date:			
NHSBT USE ONLY					
Hemajot 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 here to show which test / tests you would like us to perform.

Please include requester's address including department, postcode and telephone number. Do not use acronyms as they may be interpreted incorrectly.

This is where the report will be sent.

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

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

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.

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