Guidance Notes: 3A

H&I Platelet Refractoriness / Transfusion Reactions 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 FULL HOSPITAL NAME
Enter ODS CODE if known

Enter PATIENT DETAILS
THREE points of I.D.

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

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

PRINT contact details

Reports will only be sent to contacts listed on the request form

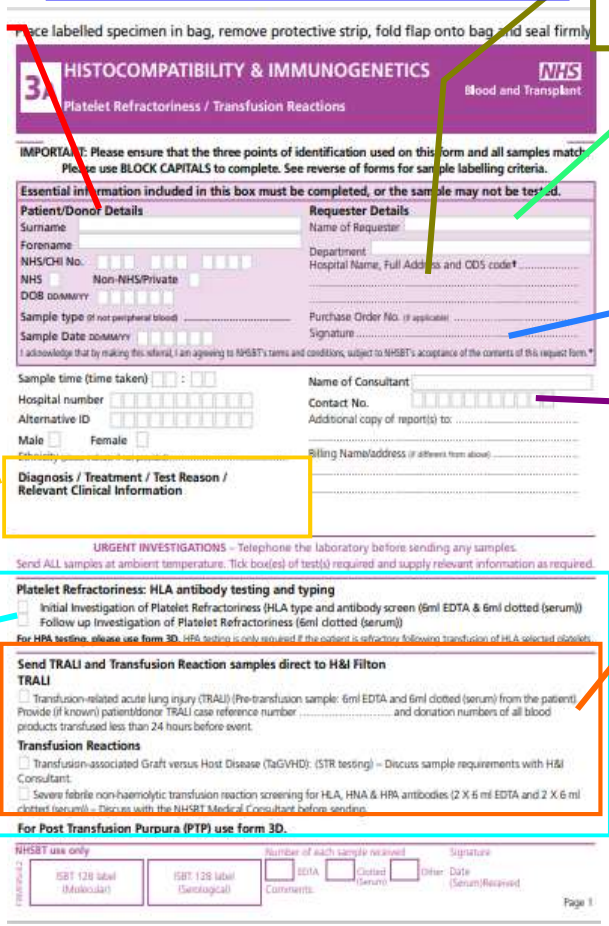
SIGN & DATE the request

Write telephone numbers clearly, direct dial

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
Birmingham	Vincent Drive, Edgbaston, Birmingham, B15 2SG	0121 278 4108
Filton (Bristol)	500 North Bristol Park, Northway, Filton, Bristol, BS34 7QH	0117 912 5733
Colindale	Charcot Road, Colindale, London, NW9 5BG	020 8957 2923
Newcastle	Holland Drive, Barrack Road, Newcastle upon Tyne, NE2 4NQ	0191 202 4410
Barnsley	Barnsley Blood Centre (Unit D), Capital Way, Dodworth, Barnsley, S75 3FG	0122 686 8241
Tooting	Cranmer Terrace, London, SW17 ORB	020 3123 8347

Guidance Notes: 3B

H&I Organ Transplant (Patients 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 **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/CHI/HCS 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

Reports will only be sent to contacts listed here

SIGN & DATE the request

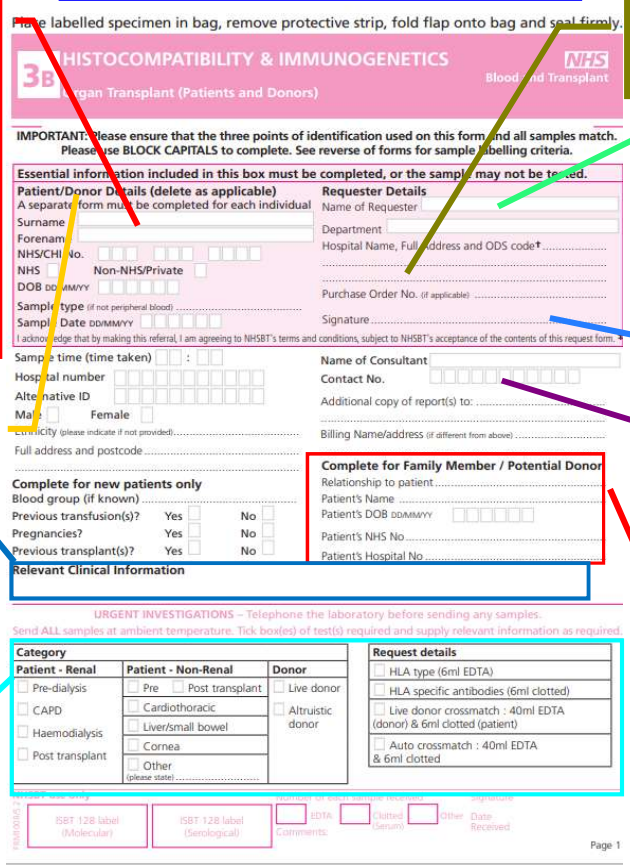
Write telephone numbers clearly, direct dial numbers are preferred

Complete for family member / potential donor

Indicate if person is a **Patient / Donor**

Enter relevant clinical details here

Please ensure correct test boxes are ticked


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

3B HISTOCOMPATIBILITY & IMMUNOGENETICS
Organ Transplant (Patients and Donors)
NHS Blood and Transplant

IMPORTANT: Please ensure that the three points of identification used on this form and all samples match.
Please use BLOCK CAPITALS to complete. See reverse of forms for sample labelling criteria.

Essential information included in this box must be completed, or the sample may not be tested.

Patient/Donor Details (delete as applicable)
A separate form must be completed for each individual
Surname
Forename
NHS/CHI No.
NHS Non-NHS/Private
DOB DD/MM/YY
Sample type (if not peripheral blood)
Sample Date DD/MM/YY
I acknowledge that by making this referral, I am agreeing to NHSBT's terms and conditions, subject to NHSBT's acceptance of the contents of this request form. *
Sample time (time taken) :
Hospital number
Alternative ID
Male Female
Ethnicity (please indicate if not provided)
Full address and postcode

Requester Details
Name of Requester
Department
Hospital Name, Full Address and ODS code†
Purchase Order No. (if applicable)
Signature
Name of Consultant
Contact No.
Additional copy of report(s) to:
Billing Name/address (if different from above)

Complete for new patients only
Blood group (if known)
Previous transfusion(s)? Yes No
Pregnancies? Yes No
Previous transplant(s)? Yes No
Relevant Clinical Information

Complete for Family Member / Potential Donor
Relationship to patient
Patient's Name
Patient's DOB DD/MM/YY
Patient's NHS No.
Patient's Hospital No.

URGENT INVESTIGATIONS – Telephone the laboratory before sending any samples.
Send ALL samples at ambient temperature. Tick box(es) of test(s) required and supply relevant information as required.

Category			Request details
Patient - Renal	Patient - Non-Renal	Donor	
Pre-dialysis	Pre Post transplant	Live donor	HLA type (6ml EDTA)
CAPD	Cardiothoracic	Altruistic donor	HLA specific antibodies (6ml clotted)
Haemodialysis	Liver/small bowel		Live donor crossmatch : 40ml EDTA (donor) & 6ml clotted (patient)
Post transplant	Cornea		Auto crossmatch : 40ml EDTA & 6ml clotted
	Other (please state)		

ISBT 128 label (Molecular) ISBT 128 label (Serological) EDTA Clotted (Serum) Other Date Received Comments:

Page 1

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Filton (Bristol)	500 North Bristol Park, Northway, Filton, Bristol, BS34 7QH	0117 912 5733
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Newcastle	Holland Drive, Barrack Road, Newcastle upon Tyne, NE2 4NQ	0191 202 4410
Barnsley	Barnsley Blood Centre (Unit D), Capital Way, Dodworth, Barnsley, S75 3FG	0122 686 8241
Tooting	Cranmer Terrace, London, SW17 ORB	020 3123 8347

Guidance Notes: 3C

H&I HSCT (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 **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/CHI/HCS 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

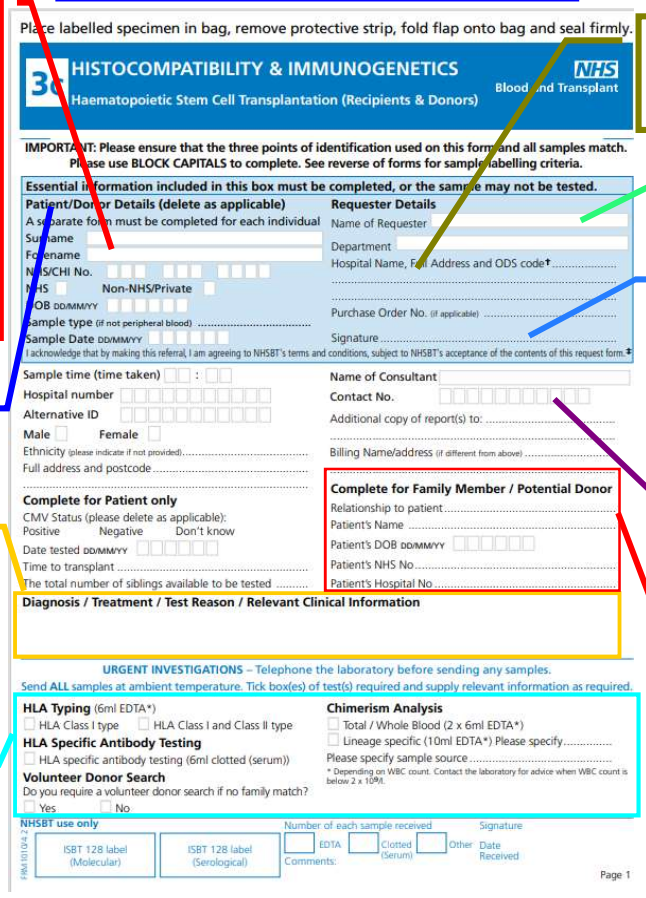
Write telephone numbers clearly, direct dial please

Complete for family member / potential donor

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

Enter relevant clinical details here

Please ensure correct test boxes are ticked


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

3C HISTOCOMPATIBILITY & IMMUNOGENETICS
Haematopoietic Stem Cell Transplantation (Recipients & Donors)
NHS Blood and Transplant

IMPORTANT: Please ensure that the three points of identification used on this form and all samples match. Please use BLOCK CAPITALS to complete. See reverse of forms for sample labelling criteria.

Essential information included in this box must be completed, or the sample may not be tested.

Patient/Donor Details (delete as applicable)
A separate form must be completed for each individual
Surname
Forename
NHS/CHI No.
NHS Non-NHS/Private
DOB DD/MM/YY
Sample type (if not peripheral blood)
Sample Date DD/MM/YY
Sample time (time taken) :
Hospital number
Alternative ID
Male Female
Ethnicity (please indicate if not provided)
Full address and postcode

Requester Details
Name of Requester
Department
Hospital Name, Full Address and ODS code†
Purchase Order No. (if applicable)
Signature
I acknowledge that by making this referral, I am agreeing to NHSBT's terms and conditions, subject to NHSBT's acceptance of the contents of this request form.‡
Name of Consultant
Contact No.
Additional copy of report(s) to:
Billing Name/address (if different from above)

Complete for Patient only
CMV Status (please delete as applicable):
Positive Negative Don't know
Date tested DD/MM/YY
Time to transplant
The total number of siblings available to be tested

Complete for Family Member / Potential Donor
Relationship to patient
Patient's Name
Patient's DOB DD/MM/YY
Patient's NHS No
Patient's Hospital No

Diagnosis / Treatment / Test Reason / Relevant Clinical Information

URGENT INVESTIGATIONS – Telephone the laboratory before sending any samples.
Send ALL samples at ambient temperature. Tick box(es) of test(s) required and supply relevant information as required.

HLA Typing (6ml EDTA*)
HLA Class I type HLA Class I and Class II type
HLA Specific Antibody Testing
HLA specific antibody testing (6ml clotted (serum))
Volunteer Donor Search
Do you require a volunteer donor search if no family match?
Yes No

Chimerism Analysis
Total / Whole Blood (2 x 6ml EDTA*)
Lineage specific (10ml EDTA*) Please specify
Please specify sample source
* Depending on WBC count. Contact the laboratory for advice when WBC count is below 2 x 10⁹/l.

NHSBT use only
Number of each sample received
EDTA Clotted (Serum) Other
Signature
Date Received
ISBT 128 label (Molecular)
ISBT 128 label (Serological)
Comments:
IFM.M1.IQ4.2
Page 1

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Histocompatibility and Immunogenetics Laboratory		Telephone
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Barnsley	Barnsley Blood Centre (Unit D), Capital Way, Dodworth, Barnsley, S75 3FG	0122 686 8241
Tooting	Cranmer Terrace, London, SW17 ORB	020 3123 8347

Guidance Notes: 3D

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

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/CHI/HCS No. = I.D.3
NHS No. is essential where available, if not available another unique identifier must be supplied

A separate form MUST be completed for each member of a NAIT family

Enter relevant clinical details here

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

Indicate if patient have received IVIg

Enter FULL HOSPITAL NAME
Enter ODS CODE if known

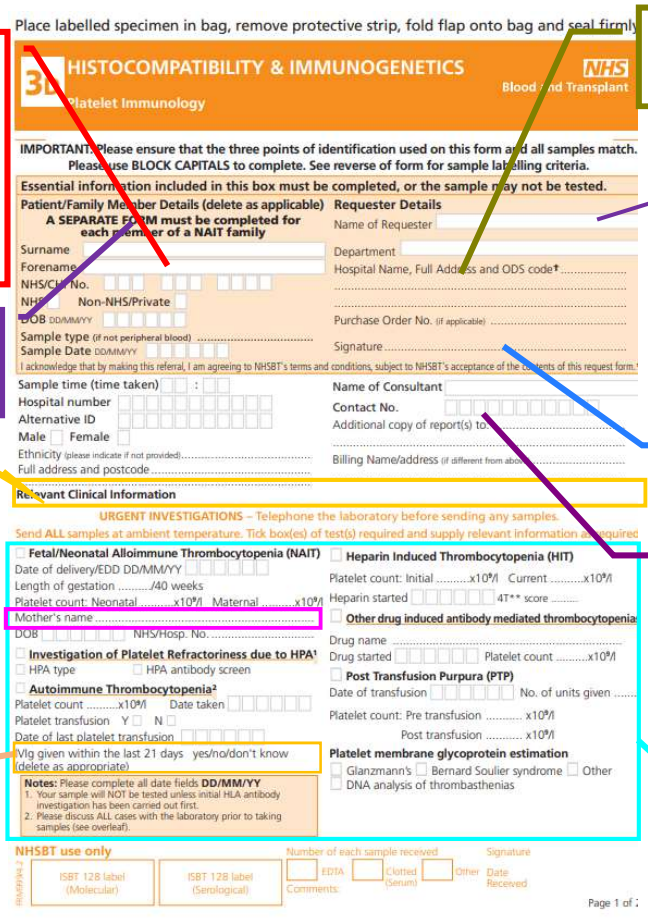
PRINT contact details

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


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

3D HISTOCOMPATIBILITY & IMMUNOGENETICS
Platelet Immunology
NHS Blood and Transplant

IMPORTANT: Please ensure that the three points of identification used on this form and all samples match.
Please use BLOCK CAPITALS to complete. See reverse of form for sample labelling criteria.

Essential information included in this box must be completed, or the sample may not be tested.

Patient/Family Member Details (delete as applicable)
A SEPARATE FORM must be completed for each member of a NAIT family

Surname
Forename
NHS/CHI No.
NHS / Non-NHS/Private
DOB DD/MM/YY
Sample type (if not peripheral blood)
Sample Date DD/MM/YY

Requester Details
Name of Requester
Department
Hospital Name, Full Address and ODS code†
Purchase Order No. (if applicable)
Signature
I acknowledge that by making this referral, I am agreeing to NHSBT's terms and conditions, subject to NHSBT's acceptance of the contents of this request form.†

Sample time (time taken)
Hospital number
Alternative ID
Male / Female
Ethnicity (please indicate if not provided)
Full address and postcode

Name of Consultant
Contact No.
Additional copy of report(s) to
Billing Name/address (if different from above)

Relevant Clinical Information

URGENT INVESTIGATIONS – Telephone the laboratory before sending any samples.
Send ALL samples at ambient temperature. Tick box(es) of test(s) required and supply relevant information as required

Fetal/Neonatal Alloimmune Thrombocytopenia (NAIT)
Date of delivery/EDD DD/MM/YY
Length of gestation ...../40 weeks
Platelet count: Neonatal .....x10⁹/l Maternal x10⁹/l
Mother's name
DOB NHS/Hosp. No.

Investigation of Platelet Refractoriness due to HPA¹
HPA type HPA antibody screen

Autoimmune Thrombocytopenia²
Platelet count .....x10⁹/l Date taken
Platelet transfusion Y N
Date of last platelet transfusion
VIg given within the last 21 days yes/no/don't know (delete as appropriate)

Heparin Induced Thrombocytopenia (HIT)
Platelet count: Initial .....x10⁹/l Current x10⁹/l
Heparin started 4T** score

Other drug induced antibody mediated thrombocytopenia
Drug name
Drug started Platelet count x10⁹/l

Post Transfusion Purpura (PTP)
Date of transfusion No. of units given
Platelet count: Pre transfusion x10⁹/l
Post transfusion x10⁹/l

Platelet membrane glycoprotein estimation
Glanzmann's Bernard Soulier syndrome Other
DNA analysis of thrombasthenias

Notes: Please complete all date fields DD/MM/YY
1. Your sample will NOT be tested unless initial HLA antibody investigation has been carried out first.
2. Please discuss ALL cases with the laboratory prior to taking samples (see overleaf).

NHSBT use only
Number of each sample received
Signature
ISBT 128 label (Molecular)
ISBT 128 label (Serological)
EDTA Clotted (Serum) Other
Date Received
Comments:

Page 1 of 2

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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

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/CHI/HCS No. = I.D.3

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

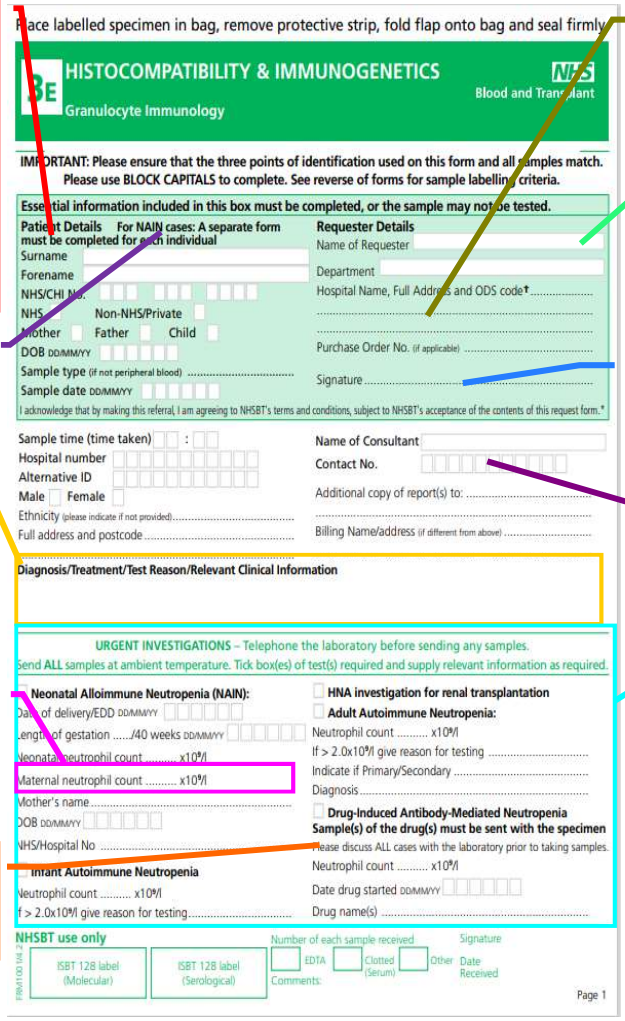
A separate form MUST be completed for each member of a NAIN family

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

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
NHS Blood and Transplant

IMPORTANT: Please ensure that the three points of identification used on this form and all samples match.
Please use BLOCK CAPITALS to complete. See reverse of forms for sample labelling criteria.

Essential information included in this box must be completed, or the sample may not be tested.

Patient Details For NAIN cases: A separate form must be completed for each individual
Surname
Forename
NHS/CHI No.
NHS Non-NHS/Private
Mother Father Child
DOB DD/MM/YY
Sample type (if not peripheral blood)
Sample date DD/MM/YY

Requester Details
Name of Requester
Department
Hospital Name, Full Address and ODS code†
Purchase Order No. (if applicable)
Signature

I acknowledge that by making this referral, I am agreeing to NHSBT's terms and conditions, subject to NHSBT's acceptance of the contents of this request form.*

Sample time (time taken) :
Hospital number
Alternative ID
Male Female
Ethnicity (please indicate if not provided)
Full address and postcode

Name of Consultant
Contact No.
Additional copy of report(s) to:
Billing Name/address (if different from above)

Diagnosis/Treatment/Test Reason/Relevant Clinical Information

URGENT INVESTIGATIONS – Telephone the laboratory before sending any samples.
Send ALL samples at ambient temperature. Tick box(es) of test(s) required and supply relevant information as required.

Neonatal Alloimmune Neutropenia (NAIN):
Date of delivery/EDD DD/MM/YY
Length of gestation ...../40 weeks DD/MM/YY
Neonatal neutrophil count x10⁹/l
Maternal neutrophil count x10⁹/l
Mother's name
DOB DD/MM/YY
NHS/Hospital No

Infant Autoimmune Neutropenia
Neutrophil count x10⁹/l
If > 2.0x10⁹/l give reason for testing

HNA investigation for renal transplantation
Adult Autoimmune Neutropenia:
Neutrophil count x10⁹/l
If > 2.0x10⁹/l give reason for testing
Indicate if Primary/Secondary
Diagnosis

Drug-Induced Antibody-Mediated Neutropenia
Sample(s) of the drug(s) must be sent with the specimen
Please discuss ALL cases with the laboratory prior to taking samples.
Neutrophil count x10⁹/l
Date drug started DD/MM/YY
Drug name(s)

NHSBT use only
Number of each sample received: EDTA, Clotted (Serum), Other
Signature
Date Received
ISBT 128 label (Molecular)
ISBT 128 label (Serological)
Comments:

Page 1

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

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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: 3F

H&I Drug Hypersensitivity / Disease association / H&I Research test request guidance information

USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS

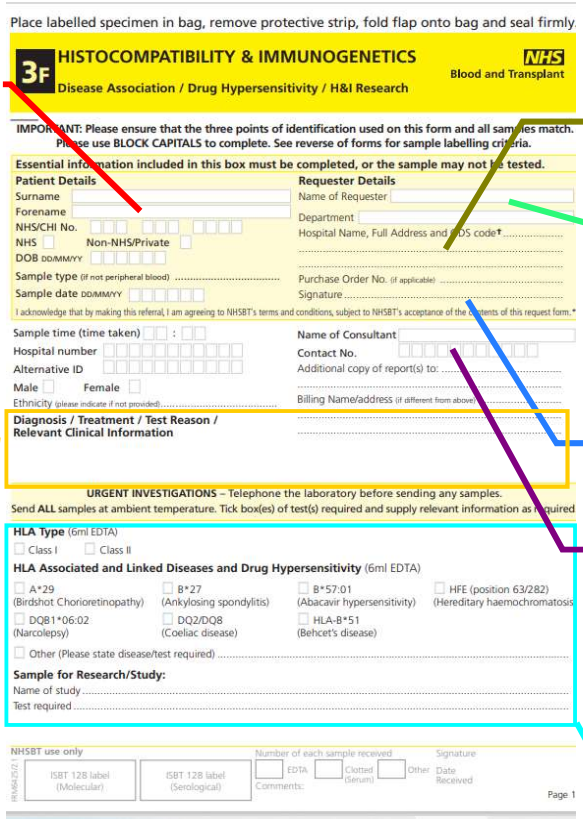
A **separate request** must accompany **every sample** including for each family member, sample date & type.
Please ensure **samples tubes** have **three points of ID** that are **as recorded on the test request** and that they are **signed and dated**.
Ensure you have identified the **referring hospital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

Reports will only be sent to contacts listed here

SIGN & DATE the request

Write telephone numbers clearly, direct dial numbers are preferred

Enter relevant clinical details

Please ensure correct test boxes are ticked and information supplied

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Tooting	Cranmer Terrace, London, SW17 ORB	020 3123 8347