

Problem Crossmatch/Antibody Information Form

Please contact Blood Bank Staff prior to submitting specimens
 Blood Bank Phone: 605.322.7110 FAX: 605.322.7150
 Please Submit: One 5 ml. EDTA (Label tube with Pt Name, DOB, and SSN)
 Segments from all crossmatched units (if applicable) (Note: Identify segments with unit number)

Patient Name: _____ Sex: M F
Last Name First Name MI

Age / DOB _____ Social Security # _____ Referring Facility's Patient ID # _____

Referring Facility: _____ Referring Physician: _____

Telephone # & Person to Call Results To: _____

Specimen Collection Date/Time: _____ Urgency/Need of Testing Completion: _____

Test(s) Requested: Problem Crossmatch Workup &/or Compatible Units (# of Units: _____)
 Antibody Identification ABO Discrepancy Workup
 Other: _____

Patient Clinical Information:

Patient Diagnosis or Disease: _____

Previous Pregnancy &/or Transfusion History: _____

Medications &/or Chemotherapy: _____

Patient ABO Rh Typing Information: ABO Forward _____ ABO Reverse _____ Rh _____

Previous Patient Antibody Identification or Antigen Typing Information: _____

Antibody &/or Crossmatch Incompatibility Detection: Grade all reactions macroscopically.

Client Site: Recipient Antibody Screen Reactions:						Client Site: Compatibility Testing Reactions (Major Crossmatch):					
AHG:	I	II	III	CC:	Interp.	Auto Control/Unit:	AHG:	CC	Interp.	Tech	
Tech					(Pos/Neg)	Unit#:					
						Unit#:					
Antibody Identification(s) [Client Site or Avera McKenna]: Results: _____ Tech: _____						Unit#:					
						Unit#:					
						Unit#:					

Avera McKenna: Antigen Typing [Units Are Tested for the Following Antigen(s): _____]					
Unit #:	Result	Tech:	Unit #:	Result	Tech: