Person Completing Requisition
Institution Client#
Dept Physician
Address
City ST ZIP
Phone (Lab) Phone (Physician)

INDIANA
IMMUNOHEMATOLOGY REFERENCE LABORATORY

Phone (317) 916-5188 x 1
Fax (317) 916-5189

Request for Antigen Negative Red Cell Unit(s)

☐ **STAT**	**Please contact Versiti partner directly when ordering STAT service**
☐ **Routine**	**Indicate date/time needed: _____**

Patient Last Name: _____ First Name: _____

Date of Birth: _____ ABO/Rh: _____ MR#: _____

Deliver to (if different than address listed above): _____

Unit Requirements

Number of Units requested:_____

☐ Irradiated ☐ CMV Negative ☐ Saline washed ☐ HgbS Negative

☐ Other: _____

*ABO/Rh compatible red cells may be substituted. Please contact your Versiti partner directly to request ABO/Rh specific units.

☐ **Check if requesting CONFIRMED units**	☐ **Check if requesting UNCONFIRMED units**
Please circle or comment, what the requested unit(s) need to be antigen negative for:	

C E c e C^w K Fya Fyb Jka Jkb M N S s

Additional Antigens/Comments: _____

IRL USE ONLY

Review:_____ Date: _____