

Prenatal Molecular Requisition

Immunohematology Reference Laboratory



Phone 414-937-6205 | Fax 414-937-6461 | Shipping Address: 638 N. 18th Street Milwaukee, WI 53233

NOTE: Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti. Client # required.

Ordering Institution Information			
Person Completing Requisition:		Provider Name:	
Dept:		Provider Contact (Phone/Email):	
Institution:			Client #:
Address:		City:	State: Zip Code:
Phone (Lab):		Special Reporting Requests (Fax Number/Email):	
Patient Information			
Last Name:		First Name:	MI:
DOB:	MRN:	Accession #:	
Sample Collection Date:		Time:	Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity:
Patient Clinical History			
Maternal ABO/Rh:		Maternal Antibodies and Titer If Known:	
Number of Pregnancies:		Currently Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Weeks Pregnant: _____	
Received Rh Immunoglobulin (RhIG)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date Last Given: _____			
Prior Transfusions: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Unit(s) transfused:	
# Units transfused:		ABO/Rh of Units:	
Spouse/Partner Name (Last, First):			Spouse/Partner DOB:
Specimen Type – See Page 2 for Specimen Requirements, DO NOT USE TUBES THAT CONTAIN SILICONE SEPARATOR GEL			
<input type="checkbox"/> EDTA/Whole Blood (lavender/pink top) <input type="checkbox"/> DNA: _____ ng/uL <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Cultured Amniocytes <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cord Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Other: _____			
Maternal blood MUST be submitted with fetal sample			
RhD Testing – Tested in WI		Reason/Indication for Submission	
<input type="checkbox"/> Weak RhD Analysis (3040) <input type="checkbox"/> Weak RhD Analysis (3040) – Reflex to Partial RhD Analysis (3240), If Indicated		Used for investigation of RhD discrepancies and determination of RhIG candidacy	
<input type="checkbox"/> Partial RhD Analysis (3240)		Used for investigation of anti-D or risk of anti-D alloimmunization in Rh Positive patients	
<input type="checkbox"/> RhD (Fetal) (3872)		Determines Rh status (positive or negative) of fetus	
<input type="checkbox"/> RhD Zygosity (Paternal/Males Only) (3874)		Determines number of RHD gene copies and likelihood of fetus inheriting the D antigen	
Genotyping			
<div> <input type="checkbox"/> Red Cell Genotyping Panel (44 Antigens) (3530) <input type="checkbox"/> C/c (3850) <input type="checkbox"/> E/e (3852) <input type="checkbox"/> K/k (3854) <input type="checkbox"/> Kp^a/Kp^b (3856) <input type="checkbox"/> Js^a/Js^b (3858) <input type="checkbox"/> Fy^a/Fy^b (3860) <input type="checkbox"/> Jk^a/Jk^b (3862) <input type="checkbox"/> M/N (3864) <input type="checkbox"/> S/s (3866) <input type="checkbox"/> Lu^a/Lu^b (3868) <input type="checkbox"/> Do^a/Do^b (3870) </div>			
VERSITI USE ONLY: _____ EDTA/Whole Blood _____ DNA _____ Amniotic Fluid _____ Cultured Amniocytes _____ CVS _____ Cultured CVS _____ Cord Blood _____ Buccal Swab _____ Other: _____ Evaluated By: _____			

Sample Identification		
All samples must include sample identification clearly marked on each specimen container. Proper identification includes full name of individual, date obtained, hospital and/or patient identification number and the identification of the individual obtaining the specimen. Federal regulations mandate that a completed laboratory requisition form accompany each sample. Blood samples must be packaged to comply with requirements of mail or overnight courier service, if used.		
Specimen Requirements – Ship Refrigerated or Room Temperature (Unless Indicated), DO NOT SEND FROZEN		
MOLECULAR TESTS	REQUESTED AMOUNT	REASON/INDICATION FOR SUBMISSION
Weak RhD Analysis	5mL EDTA whole blood (lavender or pink top)	Used for investigation of RhD discrepancies and determination of RhIG candidacy
Partial RhD Analysis	5mL EDTA whole blood (lavender or pink top)	Used for investigation of anti-D or risk of anti-D alloimmunization in Rh Positive patients
RhD (Fetal)	FETAL: 7-15mL Amniotic Fluid or 5-10mg CVS <u>*Send Room Temperature*</u> Backup Culture (highly recommended): Two (2) T25 flasks Cultured Amniocytes or CVS (2×10^6 minimum) <u>*Send Room Temperature*</u> MATERNAL: 3-5mL EDTA whole blood for MCC (lavender top)	Determines Rh status (positive or negative) of fetus
RhD Zygosity (Paternal/Males Only)	3-5mL EDTA whole blood	Determines number of <i>RHD</i> gene copies and likelihood of fetus inheriting the D antigen
Red Cell Genotyping Panel	5mL EDTA whole blood (lavender or pink top)	