Place Armband Sticker Here

# 30 Day Specimen – Pre-op Type & Screen

QUALTEX LABORATORIES
An affiliate of South Texas Blood & Tissue Center

## PATIENT INFORMATION

**Patient Name:**

**Last:** _____ **First:** _____ **Middle:** _____

**Patient Unique ID # (i.e., SSN, MR#):**_____ **Date of Request**_____

**Date of Birth**_____ ❑ **M** ❑ **F** **Attending Physician:**_____

**QualTex Use Only:**
History:

_____
Issued: Order ID / Ship ID

_____ _____/_____
**Specimen Expiration Date:

_____

## PART A TO BE COMPLETED BY THE PATIENT OR PATIENT REPRESENTATIVE –

**NOTE: Patient is eligible for 30 day Type & Screen if all questions below are answered NO.**

| | CHECK ✓ ONE: |
|---|---|
| Has patient been transfused with blood or blood products in past **3** months? ***(For Example:*** *RBC, platelets, plasma, cryoprecipitate, granulocytes, transplant, stem cells, IV-IgG or Gamma Globulin.)* | ❑ **YES** ❑ **NO** ❑ **NOT SURE** |
| Has patient required intubation or been under general anesthesia in past **3** months? | ❑ **YES** ❑ **NO** ❑ **NOT SURE** |
| Is patient pregnant or had miscarriage or abortion in past **3** months? | ❑ **YES** ❑ **NO** ❑ **NOT SURE** ❑ **N/A (Not Applicable)** |
| Is patient scheduled to receive blood, blood products, transplant, Stem Cell infusion, IV-IgG or Gamma Globulin prior to this surgery? | ❑ **YES** ❑ **NO** ❑ **NOT SURE** |

***WARNING TO PATIENT OR PATIENT LEGAL REPRESENTATIVE*:** If you have recently received transfusions or other exposures to blood, or will receive them prior to the day of surgery, or you are not sure, then you should not participate in this protocol. Such exposures might cause your immune system to reject blood transfusions selected with this specimen, resulting in a serious transfusion reaction. Please notify the anesthesiologist prior to your surgery if you have had any additional transfusions or exposures not mentioned today.

_____ _____
**Signature of Patient or Patient's Legal Representative** **Today's Date**

## HEALTHCARE FACILITY INFORMATION:

**Name:** _____

Address: _____

Phone #: _____

Fax #: _____

## PHLEBOTOMIST INFORMATION:

**Phleb. Name**: (Please Print)_____

**Phleb. Signature**:_____

**First Draw**: _____ _____
**Date** Sample Collected **Time** Sample Collected

**Second Draw**: _____ _____
**Date** Sample Collected **Time** Sample Collected

**Verified by:** _____
*(Signature-different from Phlebotomist)*

**HEALTHCARE PRACTICIONER: Verify all answers are NO, forward with patient specimen to STBTC**
**For sample pick up call 210-731-5555 or 800-292-5534. Sample pick up may also be ordered electronically. Call 210-731-5509 for questions.**

## PART B FOR QUALTEX LAB USE ONLY: (Fax Below Approval To Healthcare Facility)

❑ Patient DOES qualify for 30 Day Type & Screen.

❑ Patient DOES NOT qualify for 30 Day Type & Screen.

* Specimen Expiration Date: _____

Tech_____ Date _____

QUALTEX IRL

SPECIMEN LABEL / ABO Rh CONFIRMATION LABEL

## PART C TO BE COMPLETED BY ANESTHESIOLOGIST OR NURSE THE DAY BEFORE OR DAY OF SURGERY

**Date of Patient Surgery:**_____

- I have re-verified that the patient's answers to the above questions have not changed.
- I have verified that the patient's name and hospital number match the information above.

**Does patient have a signed consent for transfusion?** ❑ **Yes** ❑ **No**

_____/_____
**Signature of Anesthesiologist or Nurse** **MD #**

**COMPONENT TYPE & # NEEDED:**

❑ Filtered Red Blood Cells: _____

❑ Autologous Red Blood Cells: _____

❑ Platelets (single donor Apheresis): _____

❑ Fresh Frozen Plasma: _____

❑ Cryoprecipitate AHF: _____

**SPECIAL REQUIREMENTS:**

❑ CMV Neg.

❑ Irradiated

❑ Washed

❑ Other: _____

**STATUS OF ORDER:**

❑ STAT

❑ ASAP

❑ ROUTINE

_____
Date Needed

_____
Time Needed

**FAX TO QUALTEX TRANSFUSION SERVICES AT 210-249-4417**

**NOTES:** If this patient is new to QualTex Labs then we require two different draws (different times). In accordance with FDA regulations samples will not be accepted if the label lacks the required information: Patient's first and Last name, patient's unique ID #, Date and time sample collected and Phlebotomist initials. * Specimen will initially expire 30 days from date of collection if all questions are answered NO and antibody screen is negative. ** Specimen will then expire 3 days from issue of first unit or 3 days from date of surgery not to exceed 30days from draw date. If new specimen is needed fill out form RL03.0040.1, Compatibility Testing Requisition.