



**John J. Moulds Scientific Services Laboratory
Special Testing Request Form
8910 Linwood Avenue, Shreveport, LA 71106
Telephone: (318) 673-1546 Fax: (318) 227-8317**

Requesting Facility

Facility name: _____

Address: _____

Telephone: _____ Fax: _____

Submitted by: _____

E-mail address for reports and charges: _____

Sample Information: Patient name and unique identifier on tubes and request must match exactly. Samples not matching the request may be discarded and the requesting facility notified to resubmit samples.

Name/unit #: _____ (Last) (First) DOB: _____ Ethnicity: _____ Sex: M F

Patient ID: _____ ABO/Rh: _____ Specimen collection date: _____

Primary clinical diagnosis: _____ Requesting physician: _____

History of pregnancy: Yes No Transplant: Yes No If Yes, date performed: _____

History of transfusion: Yes No RBC transfusion within last 3 months: Yes No Unknown

If Yes, Total RBC units in last 3 months: _____ Date of most recent transfusion: _____

History of antibodies, including this submission: Yes No Specificity(ies) _____

Comments/additional information: _____

Blood Group Genotyping

Complete Red Cell Genotype

RHCE Genotype

Indicate serological result(s) _____

RHD Genotype

Indicate serological result(s) _____

Monocyte Monolayer Assay

Indicate antibody(ies) to challenge: _____

Reaction strength and methodology: _____

STAT (MMA only, additional fees applied)

Sample Requirements

Prepare samples for shipping using standard protocols for biological specimens. Send to the address at the top of this form.

Test requested	Sample requirement
Genotyping	1 x 5 mL EDTA tube OR extracted DNA
MMA	1 x 7 mL EDTA tubes AND 2 x 7 mL serum tube Please submit RBC segments if transfusion is anticipated.

NOTE: Please contact the Scientific Services Laboratory (318-673-1546) for assistance with all sample referrals.

LifeShare Use Only:

SS#: _____ IRL LIS #: _____ Invoice#: _____

✓\$: _____ LabServ: _____ Emailed: _____

SS-0001

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