

CANADIAN BLOOD SERVICES – DIAGNOSTIC SERVICES PERINATAL SCREEN REQUEST

PLEASE NOTE: Blood samples are not collected at Canadian Blood Services (CBS)

All information must be complete or testing will not be performed

| Maternal Information (Maternal Label – optional) | To be Completed by Physician |
|--|---|
| Surname of Mother | Hospital for Delivery (in full) |
| Given Name(s) | Unexpected antibodies present? Antibody(s) _____ CBS Reference no: _____ |
| Date of Birth yyyy mmm dd | Expected Date of Delivery yyyy mmm dd |
| Personal Health Number PHN (or Unique number if no PHN) | RhIG given this pregnancy Specimen collected before injection? <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |

| Paternal Information | Mother's information must be complete when submitting Father's specimen |
|--|---|
| Surname of Father | Given Name(s) |
| Date of Birth yyyy mmm dd | Personal Health Number PHN (or Unique number if no PHN) |

| Physician / Midwife | All information must be complete (Please indicate clinic name) Results faxed within 72 hours of sample receipt |
|---|---|
| Physician name / Midwife Name Billing number | Physician name / Midwife Name Billing number |
| Address | Address |
| City Prov Postal Code | City Prov Postal Code |
| CLINIC NAME FAX Number Phone Number | CLINIC NAME FAX Number Phone Number |

| Copy to | Copy to |
|---|---|
| Physician name / Midwife Name Billing number | Physician name / Midwife Name Billing number |
| Address | Address |
| City Prov Postal Code | City Prov Postal Code |
| CLINIC NAME FAX Number Phone Number | CLINIC NAME FAX Number Phone Number |

| Specimen Collection | Label tubes with full name, PHN (or other unique number) and date of collection Ensure that information on specimens EXACTLY matches information on requisition | |
|--|--|--|
| <input type="checkbox"/> Mother – Routine or Infertility Initial & 26 weeks Draw one 6 or 7mL EDTA | <input type="checkbox"/> Mother – Clinically Significant Antibody When requested by CBS Diagnostic Services Draw three 6 or 7mL EDTA | <input type="checkbox"/> Father – When requested by CBS Diagnostic Services Draw one 6 or 7mL EDTA |
| Date of Collection yyyy mmm dd | Collected by | Collection Facility |

Canadian Blood Services, Diagnostic Services ♦ Fax (604) 874-6582 Phone (604) 707- 3527
BC & Yukon Centre, 4750 Oak Street, Vancouver, BC, V6H 2N9

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The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.