MOLECULAR IMMUNOHAEMATOLOGY REFERENCE LABORATORY
Aberdeen & NE Scotland Blood Transfusion Centre

Request for Fetal Typing from Maternal Blood / Amniotic Fluid / CVS

Patient Details	
Surname	
Maiden Name	
First Name	
Date of Birth	
Previous BTS Number	
CHI Number	
Hospital Unit Number	
Sample Date & Time	
Gestation (weeks)	
EDD	
High Infection Risk?	
Ethnic Origin of Patient	
Blood Group of Patient	

Maternal Antibodies	Present	Absent	Level
Anti-RhD			
Anti-RhC			
Anti-Rhc			
Anti-K			
Anti-HPA-1a			
Other (please specify)			

Tests Requested	
RhD	
RhC	
Rhc	
K (Kell)	
Other (please specify)	

Partner details	
Name of Partner	
Date of Birth	
CHI / Hospital Unit Number	
Ethnic Origin of Partner	
Blood Group of Partner	
Phenotype of Partner	

NEBTS LABORATORY USE ONLY	
Traceline Sample No:	Traceline ID No:
	Date & Time Received:

Sample Type(s) Enclosed (tick boxes)

Typing from amniotic fluid / CVS	
10mL amniotic fluid / CVS	
7mL EDTA blood from patient	
7mL EDTA blood from partner	

Typing from maternal blood	
2x7mL EDTA blood from patient	
2x7mL EDTA blood from partner	

Do not send DNA prepared from plasma. Ship at room temperature
Sample must arrive at Aberdeen Blood Bank within 48 hours of being taken (send by post preferred)

Reason for request and relevant clinical history:
(please attach copies of any relevant reports)

Consultant Responsible: _____

Please send samples to:

c/o Professor SJ Urbaniak
Molecular Immunohaematology Laboratory
Scottish National Blood Transfusion Service
Foresterhill Road, ABERDEEN, AB25 2ZW
Tel: 01224 685685, Fax: 01224 698899

E-mail: stanislaw.urbaniak@nhs.net / annetaylor@nhs.net

Name & Address of Sender: [PLEASE PRINT]
Name:
Address:

Telephone:
Fax:
E-mail:
Signature:

Name and address for report, if different from sender:
[PLEASE PRINT]