Referral and Sampling Guide

Fill the form and mark the sample container

① **Identification**

If possible, state the full name and date of birth.
If appropriate, give other identification numbers e.g. :
Hospital number, social security number.
If sending amniotic fluid for fetal blood group genotyping, mark the identity of the fetus as ”Unborn child to ……………………………….”.
The mother's name and date of birth

② **Etnic/geographic origin**

If possible, describe the patient's ethnic origin. This information is not mandatory but is helpful when provided, especially when genotyping for the ABO and Rh systems since genetic backgrounds of blood groups can differ significantly between ethnic groups.

③ **Antibody status**

Note all antibody specificities present, even if the patient has antibodies to other blood groups that appear irrelevant for the requested test. If performed, complement with results from antibody titration or quantification tests.
Record the mother's antibody specificities when sending amniotic fluid or a maternal blood sample for fetal blood group genotyping.

④ **Nature of the sample**

When sending DNA, describe the sample or cell source (e.g. peripheral blood, buccal smear, urine etc).

⑤ **Phenotype**

Note, if possible, the phenotype by graded reactions or attach a copy of the testing protocol. Record the mother's phenotype when sending amniotic fluid or a maternal blood sample for fetal blood group genotyping.

⑥ **Genotype**

Note, if performed, results from previously performed genotype analysis.

⑦ **Analysis**

Mark or describe the requested analysis.

⑧ **Sampling**

Peripheral blood: One, or optimally two, EDTA or CPD/ACD tubes.
Do not open tube after sampling if possible. This is especially important if analysis of fetal DNA in the mother´s plasma will be performed.

Amniotic fluid should be dispensed into a sterile tube or container without any additive. A sample volume of 5-10 mL is desirable. Less is possible.

Transportation and address

Label the package with storage conditions. Preferably, send samples by ‘express’ mail, courier or by air freight ensuring door-to-door delivery to:

Blodgruppsgenomisk typning (KIT)
Akutgatan 8
SE-221 85 Lund
Sweden

Questions?

asa.hellberg@skane.se (primary address) or Martin_L.Olsson@med.lu.se

Request for Genomic DNA Typing of Blood Group Antigens

Referring laboratory/center	Date of birth and/or identification number ①
Contact person	
Phone	**Name** (last name, first name)
Fax	For laboratory use only: LID
Billing address	
VAT no.	

Ethnic/geographic origin ②		**Obstetric history**	Pregnancies	Children	Ongoing pregnancy Gestation week
Transfusion history?	No ☐ Yes ☐ Date: ……………………….	**Blood group antibodies?** ③	No ☐ Yes ☐ Specificities: ………………………………………..		

Sample material ④
Mark with **X** or decribe

Peripheral blood	Peripheral blood for analysis of fetal DNA	Amniotic fluid	Other? State source	DNA? Prepared from what source?

Phenotype ⑤

ABO	RhD	Additional phenotype information

Genotype ⑥

If available:

Analysis ⑦ (mark with **X**)

ABO incl. flow cytometry	*RHD*	*RHCE*	*RHD*-zygosity	*FY*	*JK*	*KEL*	*MNS (S/s)*

FUT2 (*Secretor status*)	P^1/P^2	*VEL*	*Human Platelet Antigens HPA* *HPA-1a/b*	*HPA-2a/b*	*HPA-3a/b*	*HPA-5a/b*	*HPA-15a/b*

Analysis combos

RHCE, FY, JK, MNS, KEL, DI, DO, CO, YT, LU	*RHD incl. zygosity, RHCE, FY, JK, MNS, KEL, DI, DO, CO, YT, LU*	High-frequency antigen screen (Co^a, HPA1a, Lu^b, Sc1, Vel)	Other genotype

Sampling ⑧	**Clinical information / reason for referral / questions**
Date **Signature**	

The referring laboratory states that the patient has been informed and has given consent for the sample and personal details to be stored for further analysis. If the sample is sent for scientific purposes, the referring laboratory has obtained the necessary approvals and informed the patient that anonymized data may be included in future research studies.

☐ NO, the patient does not agree.

☐ YES, the patient has agreed to the above