ALLINA MEDICAL LABORATORIES
Allina Hospitals & Clinics

KLEIHAUER REQUEST FORM

All requests for this test must be accompanied with this form. Any delays in returning this form or any incomplete information will delay completion of the test results. Please notify the Central when a specimen is being sent. Please call 612-863-1910 and indicate the urgency for test results.

Patient Label: Epic/MR#:	Age:	H #: Must be assigned at site of origin

Ordering Physician:	**For Lab Use Only**
Phone # for results:	Results called to: ______________ Date and time: ______________ Location: Phone #: Tech:

☐ ANW	☐ Unity BB	☐ Mercy BB	☐ United	☐ Buffalo	☐ Other:
612-863-1910	763-236-4805	763-236-8153	651-241-8753	763-684-7855	Phone#:

Source of Specimen:	Indication:
☐ Maternal Blood ☐ Intrauterine (PUBS) ☐ Other	☐ Prenatal Acute Trauma ☐ Newborn Infant with anemia ☐ Stillborn infant ☐ Other
Date collected:	**For Blood Bank Use Only:** ☐ Rh Negative mother / Pos rosette

ADDITIONAL INFORMATION

Blood Type	ABO	RH	Antibody Screen
Mother			☐ Neg ☐ Pos
Infant			List Antibodies if present

Weeks of Gestation		Other Information:
Date and time of delivery		
Maternal Weight		
Date received		

RESULTS

Fetal/ Adult RBC Ratio	
Tech	

Note: If Ratio is >0.004 on an Rh negative mother send the sample to blood bank for Rosette testing.

Pathologist Use Only:

Estimated Fetal whole blood volume in maternal circulation:
Call Blood Bank if > 1 dose of Rh Immune Globulin indicated? Y / N Talked to:
Other Comments:

Reading Pathologist:	Date:

Revised 3/2008