

Appendix 2 – Antenatal Blood Group Serology Request

Location
Clear details of where to send the report is required. E.G. Please state if Royal Glam or Royal Gwent-RG is not sufficient

Lead Professional
Consultant or Midwifery led name is required

ID of the woman
Clear identification of the woman is required to ensure results are attributed to the correct individual.

Use address labels **only** if authorised by the individual organisation

Requested by
Name, signature and contact details required to show consent and to enable rapid reporting of problems with sample or result

EDD/previous pregnancy/Previous HDFN required by the lab

Take a blood sample before the administration of RAADP
Routine blood grouping and antibody screening sample **must** be taken prior to administration of RAADP. This is important to avoid any unnecessary further blood tests during pregnancy.
If anti D has been given before the blood sample is taken, the lab will not be unable to differentiate between prophylactic anti D detected after prophylaxis or immune anti D and 2 weekly samples will be requested. Record here if any anti D has been given during this pregnancy. Ensure date and dose is recorded

Failure to complete:
The person taking the sample must complete this section on the day that the sample is taken.

There must be a legible signature, even if it is the same health professional who requested the test and is signing the card twice

Lab Use Only
This section to be completed on receipt at the lab

First sample/Repeat sample
Tick one box only, depending on whether this is the sample taken at booking, or a repeat sample during the pregnancy

Additional relevant information
E.g. It is important to document here if this is a sample to check antibody titre levels, or the woman is known to have antibodies previously.
(Please send 2x 6ml pink (EDTA) bottles if this sample is to check titre levels for known maternal antibodies)

Antenatal Blood Group Serology Request

Location	Lead Professional	Lab Specimen N ^o
Hospital N ^o	NHS N ^o □ □ □ □ □ □ □ □	
Last Name (Block Capitals)		D.O.B. (dd/mm/yyyy)
First Name/s (Block Capitals)		Private <input type="checkbox"/>
Address: <i>Address labels only if authorised by the individual Organisation</i>		NHS: <input type="checkbox"/>
		Postcode
Requested by:	Signature:	Tel no/bleep
Date		
FAILURE TO COMPLETE THIS SECTION WILL RESULT IN SAMPLE REJECTION		
Positive patient identification obtained verbally YES / NO		
Date sample taken:	Time:	
Taken by (Signature)		Print name
EDD (dd/mm/yyyy)		
Previous pregnancy...Yes / No		Laboratory Use Only Sample acceptance criteria met: YES / NO Sample checked by:
Previous HDN Yes / No		
Has anti-D been given in this pregnancy? Yes/No		
Date Given:	Dose:	
First Sample <input type="checkbox"/> Repeat Sample <input type="checkbox"/>		
Additional relevant information (eg previous antibodies detected)		