# POST NATAL REQUISITION

**BABY’S INFORMATION (Cord blood)**

For multiple births, use white page only for additional cord blood samples.

**COPY TO:**

1. Last Name                  Full First Name                  Location
2. Last Name                  Full First Name                  Location

**PRIORITY:**

- ROUTINE
- STAT
- TIMED
- ASAP

**DATE TO BE COLLECTED:**

**TIME TO BE COLLECTED:**

**CLINICAL INFORMATION:**

- PATIENT LOCATION
- REQUISITIONED BY:

## CORD BLOOD

### Tests

- NEWBORN CORD SPECIMEN
- DATN
- BGCO/BGCOV/BGCOA
- Fetal-Maternal Investigation
- Cord DAT
- Cord pH (rural sites only)

### Cord blood sample requirements

- 1 x 4 mL or 6 mL red top tube
- 1 x 4 mL or 6 mL lavender top EDTA tube

### Cord blood sample labelling requirements

- Mother’s last and first name
- Mother’s identification number (RHRN/PHN)
- Baby’s last name and gender/first name
- Baby’s identification number (RHRN/PHN)
- “Cord blood”

### Cord blood accession number

- Maternal ABORh: ___________________
- Maternal Antibody screen: ______________ Date: _____________
- ROSE ordered: □ Yes □ N/A

**COLLECTED BY**

**FASTING HOURS (FC)**

- N/A

**FOR LABORATORY USE ONLY**

**CORD BLOOD ACCESSION NUMBER**

Laboratory Information Centre: 403-770-3600  www.calgarylabservices.com
### Post Natal Requisition

**Baby’s Information (Cord Blood)**

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**Ordering Clinician**

- Last Name
- Full First Name
- If required, phone or fax: ___________ Number

**Copy To:**

1. ______________________ ______________________ ______________________
   - Last Name
   - Full First Name
   - Location
2. ______________________ ______________________ ______________________
   - Last Name
   - Full First Name
   - Location

**Priority:**

- Routine
- Stat
- Timed
- ASAP

**Clinical Information:**

- Patient Location
- Requisitioned By

**Mother’s Information**

Mother’s orders on yellow page.

Null addressograph imprint or patient label to ALL PAGES, or clearly print patient’s full name (last name, full first name), date of birth, gender, Personal Health Number and Medical Record Number.

**Tests on Mother**

- **Type:**
  - □ Maternal Rh
  - □ FMH PB
  - □ Fetal-Maternal Hemorrhage

**Mother’s Sample Requirements**

1 x 4 mL or 6 mL lavender top EDTA tube

**Mother’s Sample Labelling Requirements**

- Mother’s last and first name
- Mother’s identification number (RHRN/PHN)

Forward requisition to Transfusion Medicine with sample(s)

<table>
<thead>
<tr>
<th>Collected by</th>
<th>Fasting Hours (PC)</th>
<th>For Laboratory Use Only</th>
<th>Mother’s Accession Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
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</tbody>
</table>

Maternal AB/Rh: ____________________
Maternal Antibody screen: __________ Date: __________
Rose ordered: □ Yes □ N/A

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www.calgarylabservices.com