Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

A. PATIENT INFORMATION (PLACE LABEL HERE or TYPE)
Last Name: _____
Given Name(s): _____
MRN: _____ DOB: (YYYY/MM/DD)_____
Address: _____
City: _____Province: _____ Postal Code: _____
Tel:_____
Health Card #:_____ Phone: _____
(Including version code)

Alloimmunized Fetal Blood Group Genotyping Requisition
Non-Ontario or Non-PSO Samples

FOR PREGNANT WOMEN/INDIVIDUALS WHO MEET ALL OF THE FOLLOWING CRITERIA:

- Presence of alloantibodies D, C, c, E and/or K (Kell) (other antibodies are not currently tested)
- Singleton or multiple pregnancy with no evidence of fetal demise/or vanishing twin in multiple gestation
- No known RHD variant or weak D phenotype (for D-antigen testing)
- No confirmed passive anti-D (for D-antigen testing)

Instructions: Ordering provider completes page one (1). Incomplete requisitions may result in testing delays or sample rejection.
Patient brings requisition to a laboratory for blood draw at greater than or equal to 16 weeks' gestation for anti-D/C/c/E or greater than or equal to 20 weeks' gestation for anti-K (Kell). ALL FIELDS ARE REQUIRED.

A. ORDERING PROVIDER		B. COPY TO PROVIDER	
Last Name:	First Name:	Last Name:	First Name:
CPSO/License # (required):	Address:	CPSO/License #:	Address:
City:	Postal Code:	City:	Postal Code:
Tel:	Fax:	Tel:	Fax:
Email:		Email:	
Signature		Additional Copy To:	

C. PATIENT CLINICAL INFORMATION

Estimated Due Date (EDD) _____ (YYYY/MM/DD) **# of Fetuses:** ☐ 1 ☐ 2 ☐ 3 ☐ Other:_____

EDD Determined by (dating ultrasound is preferred):
☐ 1st Trimester Ultrasound ☐ 2nd Trimester Ultrasound ☐ Last Menstrual Period ☐ Unknown

D. TEST INFORMATION

☐ Initial sample ☐ Repeat sample ☐ Additional sample for K (Kell) 28 weeks' gestation ☐ Resubmitted Requisition – Incomplete Original

Patient Antibodies – Indicate antibodies present in current or past pregnancies. **Allo-FBGG test will only be done for those marked "Yes"**		**Minimum Required Gestational Age** (on date of collection)
Anti-D (Do not test for confirmed passive anti-D, D variant, or weak D	☐ Yes	greater than or equal to 16 weeks gestation
Anti-C (big C)	☐ Yes	
Anti-c (little c)	☐ Yes	
Anti-E	☐ Yes	
Anti-K (Kell)	☐ Yes	greater than or equal to 20 weeks gestation

E. SAMPLE INFORMATION AND TRANSPORTATION

Send samples to ensure they arrive within **48 hours for anti-K and 72 hours of collection for anti-D/C/c/E.**
Store and ship the samples at 15°C to 25°C. Do not freeze.
If timely delivery of sample is not possible, please see Lab Test Catalogue link below.

☐ EDTA (lavender/pink top) – 16 mL whole blood
☐ Frozen Plasma: processed by following the protocol linked here:
[https://eportal.sinaihealth.ca/LabCatalogue/home/index?search=Alloimmunized+Fetal+Blood+Group+Genotyping]

Please provide processing date and time: _____

Collection Date (YYYY/MM/DD): _____ Collection Time (HH:MM): _____ Collected by: _____ Accession/Order # _____	Collection Site Name: Processing Site Name:	LAB LABEL

Mount Sinai Hospital Laboratory (FOR LAB USE ONLY):

☐ EDTA Blood ☐ Frozen Plasma ☐ Other (specify): _____	**# of Tubes Received:** **# Hemolyzed** **Comments**	Comments:

C489

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Alloimmunized Fetal Blood Group Genotyping Requisition
Non-Ontario or Non-PSO Samples

Ordering and Sample Collection Instructions

To avoid transport delays (e.g., weekends or holidays), please confirm courier pick-up and delivery schedules prior to collection and shipment, and ensure the sample can be received within the required timeframe. For more details on Collection, Shipping, and Reference Information, please access our website at: https://www.sinaihealth.ca/areas-of-care/pathology-and-laboratory-medicine

All fields are required; incomplete requistions may result in testing delays or sample rejection

C. Patient Clinical Information:
- Must be filled in by the ***ordering provider***

D. Test Information: Specify whether the sample is:
- **Initial**:
  - First sample submitted for fetal antigen(s) testing in current pregnancy.
- **Repeat:**
  - Redraw is required after a test result of "failed," "not tested," or "inconclusive" due to issues such as insufficient sample quality, quantity, or integrity.
- **Additional test for K (Kell) at greater than or equal to 28 weeks gestation**
  - Resubmitted Requisition – A resubmitted complete requisition.

E. Transport Instructions
- Package sample in a leak proof, suitable container in compliance with Transportation of Dangerous Goods regulations
- When using Zippered transport bags, place all samples from one patient into a single bag
- Attach the completed requisition form to the outside of the bag (either clipped or placed in the outer pouch)
- Refer to Lab Test Catalogue at the link below for detailed transport instructions.
  https://eportal.sinaihealth.ca/LabCatalogue/home/index?search=Alloimmunized+Fetal+Blood+Group+Genotyping
- Clearly label outer container with sender's name, address and receiver's address
- Samples must arrive at Mount Sinai **within 48 hours of collection for anti-K and 72 hours for anti-D/C/c/E**
- **Samples will be received Monday to Sunday 24/7**

E. Sample Collection Information:
To be filled in by **collection site staff.**
Sample Requirement: Collect a minimum of 16 mL whole blood in an EDTA tube (lavender or pink top).
If timely delivery of sample is not possible, see the Lab Test Catalogue for frozen plasma protocol.
https://eportal.sinaihealth.ca/LabCatalogue/home/index?search=Alloimmunized+Fetal+Blood+Group+Genotyping

Tube handling:
- Do not open tube after collection.
- Do not perform other tests on the sample
- Maintain the sample at room temperature 15 °C–25 °C during storage and shipping (transit). Do not freeze. Sample should not be discarded if inadvertently refrigerate; testing lab will make final accept/reject decisions.

Labelling:
- Include 2 unique identifiers: full name and health card number (DOB or clinic/hospital # may be used if there is no HCN) (must match requisition).
- Requisition and tubes must be labelled, dated, and signed by the collector.

Handwritten changes on the sample or form may invalidate testing. Minor alterations must be initialized by the collector.

Results:
- Test results are generally available within 10 business days. Reports will be sent by mail to the ordering provider (and any copied providers) via Canada Post.
- If fax delivery is preferred, a completed Fax Agreement Form must be submitted to Mount Sinai following the instructions provided on the form. One agreement is required for each provider.

  Form available here:
  https://www.sinaihealth.ca/areas-of-care/pathology-and-laboratory-medicine/diagnostic-medical-genetics

Shipping Address
(Receiving Site):
Core Laboratory Receiving –
Mount Sinai Hospital
600 University Ave, 11th Floor, 11C-313
Toronto, ON , M5G 1X5
416-586-4688

Direct Inquiries To:
Advanced Molecular Diagnostics,
Pathology and Laboratory Medicine
600 University Ave, Room 11D-410 Toronto, Ontario, M5G 1X5
Tel: (416) 586-4800 x 5974
Fax: (416)-619-5532
FBGG.MSH@sinaihealth.ca

Courier Instructions:
Enter the hospital at the back of the building (Murray St Entrance)

Access to the Laboratory is via the University Avenue elevators ONLY