STANFORD
UNIVERSITY
MEDICAL CENTER
Stanford Hospital & Clinics
Lucile Salter Packard Children's Hospital

Memorandum

To: All SHC and LPCH Service Providers

From: Lee C. Chua, Transfusion Service Manager
Lawrence T. Goodnough, MD, Director of Transfusion Service

Date: 6/27/2014

Re: **Specimen Volume Required for Verification of Blood Type Draw**

Effective **7/12/2014,** all specimens drawn that DO NOT MEET THE MINIMAL VOLUME requirement (see below) will be REJECTED.

In order to comply with the AABB standards for Blood Type Verification testing, we will now reinforce the specimen volume requirement for the Blood Type Verification testing as specified on the "Notification for Blood Type Verification Draw" form.

One 2-ml lavender top (adult)

or

One 0.5-ml bullet lavender (pediatric) tube

The requests for Blood Type Verification draw in the Hospital Information System, EPIC remain unchanged.

300 Pasteur Drive • Room H1402, M/C 5626 • Stanford, CA 94305
t: 650.723.7346 • f: 650.723.9178

Title: ABO and Rh Testing

Appendix A: Request for Verification of ABO/Rh Draw

Patient Name _____ Contact person / Location _____

MRN _____ Date/time of Request _____

DOB _____ Requested by (TS Staff) _____

This patient has no blood type history at Stanford Hospital & Clinics Transfusion Service. The SHC Quality Improvement/Patient Safety Committee (QIPSC) and the LPCH Patient Safety Committee have approved that a second specimen must be drawn for ABO/Rh verification.

1. **Order in HIS (EPIC or LINKS) as Blood Type Verification.**
2. Identify patient: label & ID band – Name, MRN, and/or DOB (date of birth).
3. Draw: One 2-ml lavender top (adult) or one 0.5-ml bullet lavender (pediatric) tube (with orange label) to be provided by Transfusion Service.
4. Label specimen with the computer generated label. (Use addressograph label for downtime).
5. Verify labeled tube with patient ID band, or have patient verify that the information on tube is correct.
6. Record date, time & initial on the tube.
7. Send specimen to Transfusion Service (TS):

SHC OR – tube # 73 or SHC - tube # 210 LPCH OR – tube # 81 or LPCH- tube # 210

8. If tube is not used, return empty tube & form to TS. Document reason for return.

Refer to Blood Collection and Patient Identification Procedure.
Contact Supervisor/Charge Tech at Transfusion Service x 3-6445 for questions.

Transfusion Service Staff Only

Patient Name _____ Contact person / Location _____

MRN _____ Date/time of Request _____

DOB _____ Requested by (TS Staff) _____

Additional Comments: