**Date of Testing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Indianapolis, IN 46202

**Antigen Screening Worksheet**

 **Form #: BBT – F105.01**

 **Manual: Testing**

**Supervisory Review/Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
|  **Unit Number or Patient Name/MRN** | **Indicate Antigen(s) being tested:**  |
|  |  |  |  |  |  |  |  |  |  |  |  |  | Cener Entry Y, N, NA | Testing Tech Initials | Peer Audit Initials |
|  **1)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  2) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  3) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  4) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  5) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  6) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  7) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  8) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  9) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  10) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Antisera** **Lot Number** **and** **Expiration Date**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  **PATIENT PHENOTYPE** **For serologic phenotype testing: Patient transfused in the last** **90 days?****No, Ag Test as needed.****Yes, cell separation is required before antigen typing (or) send patient sample for RBC molecular.**  |
| ***Is Antisera QC Completed?***  ***Y=Yes***  |  |  |  |  |  |  |  |  |  |  |  |  |  |