**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*** |  |  |  |  |  |  |  |  |  |  |  |  |  |