Hemolytic Disease of the Newborn (HDN) Investigation Request Form

☐ *C.H.C.S.J.* ☐ *K.W.H.* ☐ *U.H.*

Patient information

Neonate's name：____________________	Mother's name：____________________
SS Nº/Admission Nº ：_______________	SS Nº/Admission Nº ：_______________
Date of birth ：__________ *(dd/mm/yyyy)*	Race：☐ Chinese ☐ Portuguese
Sex ：☐ M ☐ F	☐ Macanese ☐ Other ______

Clinical information

History of pregnancy

Gestation：__________ Para：__________ Abortion：__________

Blood transfusion history

Neonate：☐ Yes ☐ No Mother：☐ Yes ☐ No

Clinical history

Laboratory result

Blood grouping

Mother ：__________________ Neonate ：__________________

Neonate (Test Date：________*(dd/mm/yyyy)*)

Total bilirubin：__________________ Direct bilirubin ：__________________

Hb ：__________________ Indirect bilirubin：__________________

Send report to：________ (department) Doctor name (with Staff no. /License no.)：____________ Tel：_________

Doctor signature：	Date：
Sample requirement： Neonate : 1.5 ml EDTA blood (cord blood preferred) Mother : 3 ml EDTA blood	Date of sample collected：________*(dd/mm/yyyy)* Time：________ *(hh/mm)*

CTS may reject the request, if:

1. Not clear of the patient identification.
2. Insufficient/ leaked sample.
3. Unmatched sample for test item.
4. Aged sample (sample stored at 2-8℃ for >7 days on day of testing)

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