Title: Allogeneic Transplant Checklist Form (NCBH)

Atrium Health Form

☐ Unrelated Allogeneic ☐ Related Allogeneic ☐ Syngeneic (Twin)

Attending Physician_____ Transplant Date: _____

RECIPIENT	DONOR
Name:	Name:
MR#:	MR#:
NMDP#:	NMDP#:
Date of Birth:	Date of Birth:
RBC Serology	**RBC Serology**
Date Tested:	Date Tested:
ABO/Rh:	ABO/Rh:
Antibody Screen:	Antibody Screen:
Antibody ID, if applicable:	Antibody ID, if applicable:
Titer Result, if applicable:	Titer Result, if applicable:
Genotype sent? Y / N Date: Time:	Genotype Sent? Y / N Date: Time:
Transfusion History: (Check CareEverywhere in EPIC and include transfusions at other institutions)	Transfusion History: (Check CareEverywhere in EPIC and include transfusions at other institutions)

Hospital Stay/Transfusion History		Hospital Stay/Transfusion History	
Nurse Coord. Contacted	Tech/Date	Nurse Coord. Contacted	Tech/Date

RBC Serology Interpretation

☐ No ABO/Rh Incompatibility ☐ Major ABO Incompatibility ☐ **Minor ABO Incompatibility*** ☐ Other RBC Incompatibility

Initials of Person Completing Form:_____ Date:_____

Retain Donor and Recipient Tubes from Blood Bank:_____ Date:_____

Print HLA Report and attach to Checklist:_____ Date:_____

Transfusion Requirements	Processing Requirements
RBCs: ☐	
PLTs: ☐	
PLASMA: ☐	
Mgmt SQ Entry: _____ Date: _____	Medical Director Review: _____ Date: _____
Mgmt review of SQ Entry: _____	DOT: SCTCT staff review: _____ Date: _____

*Print BAD file tranfusion requirements, circle RBC requirement and attach to checklist

This form MUST be reviewed for processing requirements and signed by management and Medical Director