



Stanton Territorial Hospital
P.O. Box 10, 550 Byrne Road
YELLOWKNIFE NT X1A 2N1

Document Name:
Crossmatch Request Form
(Within NWT)

Distribution:
Transfusion Medicine Manual

Document Number:
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All requests must be faxed to Stanton Blood Bank **Fax: 867-669-4306**

***STAT ORDERS MUST ALSO BE PHONED**

	Monday - Friday	Weekend/STAT holidays
Phone LAB: 867-669-4373	Hours: 0630 to 2300	Hours: 0630-1500
Phone PCC: 867-445-8770	Hours: 2300 to 0630	Hours: 1500-0630

Hospital: _____ Date: _____ Time: _____			
Delivery Priority: ROUTINE <input type="checkbox"/> STAT* <input type="checkbox"/>			
Delivery Mode: _____	Date/Time Required By: _____		
Requested By: _____			
Comments: _____			
Ordering Physician: _____			
Patient Information	Initials: _____ Birthdate: _____ Antibodies Identified: _____ Healthcare Number: _____ Ident/Band Number: _____		
Units Required:	Amount: _____ ABO/Rh: _____		
Circle Required Negative Antigens	C E c e K FyA FyB JkA JkB S s		
Additional Antigens _____			
ABO Compatible Substitution Acceptable?	Yes <input type="checkbox"/>	If NO why?	
	No <input type="checkbox"/>		
Additional Requirements: (Check all that apply)	<input type="checkbox"/> Irradiated	<input type="checkbox"/> IgA deficient Recipient	<input type="checkbox"/> Surgery Date:
	<input type="checkbox"/> Washed	<input type="checkbox"/> Less than _____ Days old	<input type="checkbox"/> Transfusion Date:
	<input type="checkbox"/> CMV Negative, Irradiated	<input type="checkbox"/> Other – Specify: _____	<input type="checkbox"/> For Stock Only

Shipping Information (to be filled in by Stanton staff)

Waybill # and Airline: _____	
Packaged by: _____	Date and Time: _____

NOTE: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against electronic version prior to use.