

INCOMPATIBLE CROSSMATCH RELEASE FORM

Physician's statement concerning order for transfusion when crossmatch compatible units are unavailable or unobtainable due to an existing patient condition or lack of availability.

I have ordered the transfusion of blood for the patient named below for the following reason(s):

I fully understand the increased risk involved to the patient in transfusing crossmatch incompatible blood.

Physician's Signature: _____

Witness Signature: _____ **Date/Time:** _____

Donation Number(s) of transfused units:

_____	_____	_____
_____	_____	_____



Patient Name: _____

Medical Record Number: _____