**TRANSFUSION SERVICES *PREADMISSION* TESTING & RED BLOOD CELL REQUEST FORM:**

 **DATE OF REQUEST: / /**

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| --- | --- |
| **PATIENT INFORMATION:**  | **SAMPLE INFORMATION** |
| *Place EPIC/Patient Computer Label Here* | **Person Completing Request**  | **Contact Phone/Pager #** |
| **Date/Time Drawn: / / :** ☐ am ☐ pm |
|  .**1st Person: Drawing sample & Verifying Patient ID** *(sign above)* **.****2nd Person Verifying Patient ID** *(sign above)* |
| **Type of Scheduled Procedure** *(if applicable)* .*OR***Indication for Transfusion**  . |
| **Date of Scheduled Procedure:**  / / .  |
| **Test(s) Ordered**: ☐ Type and Screen ☐ ABO/Rh Type only☐ Type + Crossmatch ☐ Direct Antiglobulin test (DAT)☐ Indirect Antiglobulin Test (antibody screen only)☐ Antibody Titer (e.g. pregnant patient) |
| **Ordering Physician:** | **Special Comments:** |
|

**Blood Product Requested:**

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|  **PACKED RED BLOOD CELLS** |
| ☐ **Anticipated Date & Time Required**  **/ / :** ☐ am ☐ pm**# Units**  (Adults & Peds pts. ≥ 30kg)**# mL**  (Pediatric patients < 30kg)**Patient Hemoglobin** *(If known)*   **g/dL** **Special Product Requirements:***(Initial order requires Transfusion Services Physician approval)*☐ Leukoreduced/CMV Safe ☐ Irradiated☐ Other .  | **Was patient transfused in last 3 mths?** ☐ Yes ☐ No  **Was patient pregnant within last 3 mths?**☐ Yes ☐ No ☐ Male patient**Tx & Pregnancy History Obtained By:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |

HMC2595 REV JUL 11