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

**DATE OF REQUEST: / /**

|  |  |  |
| --- | --- | --- |
| **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:** | |
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**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