**TRANSFUSION SERVICES TESTING & BLOOD PRODUCT REQUEST FORM:**

**DATE OF REQUEST: / /**

|  |  |  |
| --- | --- | --- |
| **PATIENT INFORMATION:** | **SAMPLE INFORMATION** | |
| *Place ORCA/EPIC 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)* | |
| **Test(s) Requested:**  □ **Type and Screen (T&S)** □ Routine □ Stat  □ **ABO/Rh Type only** □ Routine □ Stat □ 2nd Sample  □ **Type and Screen + Crossmatch** □ Routine □ Stat  □ **Crossmatch** – Patient has an active unexpired T&S  □ **Direct Antiglobulin Test** □ **Indirect Antiglobulin Test** |
| **Prenatal Test(s) Requested:**  □ **Type and Screen** □ **Antibody Titer**  **□ Indirect** **Coombs** **□ Direct Coombs** | **QUESTIONS FOR PRETRANSFUSION PATIENTS** | |
| **Was patient pregnant within the last 3 months?**  □ Yes □ No | |
| **Ordering Physician:** | **Was patient transfused within the last 3 months?**  □ Yes □ No □ Unable to Answer*(e.g unconscious)* | |

**Blood Product Requested:** *(For Granulocytes use the Granulocyte Request Form)*

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| **PACKED RED BLOOD CELLS**  **□ Patient has active unexpired Type & Screen** | **PLATELETS** *Single donor apheresis platelets will be routinely provided.* | **THAWED PLASMA** |
| □ **Emergency Release-** **(5 minutes)** Uncrossmatched ABO group O units will be provided*. (Once ABO group available, type specific units will be issued)*  □ **Stat – (50 minutes)** Crossmatched Units. *(If no current type and screen or patient has RBC antibodies, cross-matched units may take ≥**40 minutes to provide)*  □ **Routine: (please specify below)**  □ Today: □ When ready OR  □ Other Date and time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Surgery □ Scheduled transfusion  **# Units** (Adults & Pediatric patients ≥ 30kg)  **# mL** (Pediatric patients < 30kg)  **Patient Hb g/dL**  **Indication for transfusion** .  **Special Product Requirements:** *(Requires Transfusion Services Physician approval)*  □ Leukoreduced/CMV Safe □ Irradiated  □ Other . | □ **Stat (10 minutes)**  □ **Routine**  □ Today: □ When ready *OR*  □ Date & Time**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **# Doses:** (Adults)  *(1 adult dose contains equiv. 5-6 units of pooled random donor/whole blood derived platelets).*  **# mL** (Pediatric pts. < 30kg)  **Platelet Count x 103/mL**  **Indication for Transfusion:** .  .  **Special Product Requirements:** *(Requires Transfusion MD approval)*  □ Leukoreduced/CMV Safe  □ Irradiated  □ Other *(please specify)*  .  . | **□ Emergency Release**  **(5 minutes)** – AB *units will be issued.*  □ **Stat- (20 minutes)**  □ **Routine:**  □ When ready *OR*  □ Date/Time\_\_\_\_\_\_\_\_  **# Units**  (Adults)  **# mL** (Peds < 30kg)  **INR .**  **Indication Tx:** .  .    **CRYOPRECIPITATE**  □ **Stat (10 minutes)**  □ **Routine (specify)**  □ Today □ When Ready  □ Date/ time\_\_\_\_\_\_\_\_\_\_  **# Units: .**  *(For adults - Cryo is only provided in pools of 6U)*  **Fibrinogen mg/dL**  **Indication Tx:** .  . |

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