**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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