OHSU HEALTH

Title: **Request for Transfusion Service Testing and Blood Products**

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Deliver specimen to 3181 SW Sam Jackson Park Rd. Portland, OR 97239 Room HRC 9D20, or Pneumatic Tube Station: 950 or 13, Transfusion Service Phone: (503)494-8537

Note: All specimens for pretransfusion testing must be labeled at the patient's bedside with patient's full name, MR#, date collected, and full signature of phlebotomist. Prior to transfusion, consent for transfusion must be documented in the patient's record.

PLEASE COMPLETE THE FOLLOWING:
I verify that the sample submitted is correctly labeled with the name/medical record number of the patient whose blood was drawn.

Signed _____Date/time: _____

Signed _____Date/time: _____
(second signature if required by outside facility policy)

Location: _____ Phone: _____ Ordering Physician: _____

Date and time needed: _____ Diagnosis/Indication: _____

Is this a Hem/Onc, solid organ, or BMT candidate/recipient? _____ Yes _____ No

Special Product Needs: Irradiated, Washed, Hgb S neg, Potassium Precautions, HLA-Matched, RBC Antigen Matched (specify antigens), Circle all that apply and include any additional instructions below:

Results will be immediately available to the patient unless you mark the box below:
□ Do not release (I reasonably believe that an Information Blocking exception applies)

Blood Product/Transfusion Service Work Requested:

____ Type & Screen ____ ABO/Rh ____ Antibody Screen ____Direct Anti-Globulin Test

____ **Red Blood Cells, Leukoreduced:** _____ unit(s) Indication: ☐ Hgb ≤ 7,☐ Hgb ≤ 8 with ACS, ☐ Clinically significant acute blood loss, ☐ Upcoming surgery, ☐Other _____

____ **Apheresis Platelets, leukoreduced:** _____ unit(s) Indication: ☐PLT≤10K, ☐PLT≤20K and signs of hemorrhagic diathesis (petechia, mucosal bleeding), PLT≤50K + clinical indications, ☐Other _____

____ **Plasma:** _____ unit(s) Indication: ☐Clinically significant bleeding and INR > 1.5 or PTT > 45, ☐Immediate need for surgical procedure/intervention, ☐Emergency reversal of Coumadin

____ **Other** (Cryo, WB, etc.) _____ unit(s) of _____Indication:_____

____ Aliquots (peds/neo): Volume _____ Product _____

____ Cord Blood Routine ____ Rh Immune Globulin Workup (____ Weeks Gestation)

____ Hold Sample, Do Not Process ____ Other (specify) _____