Seattle Children's®
HOSPITAL · RESEARCH · FOUNDATION

REQUEST FOR TESTING AND BLOOD COMPONENTS (for EMERGENCY and DOWNTIME USE ONLY)

PATIENT INFORMATION - Refer to Epic Read-only to find patient Type and Screen expiration date/time and Blood Special Requirements

MEDICAL RECORD NUMBER:	ATTACH PATIENT DEMOGRAPHIC LABEL IF AVAILABLE	**Ordering Physician Name** (MUST BE LEGIBLE):
PATIENT LAST NAME:		**Physician Signature: X**_____
PATIENT FIRST NAME:		Date: _____ Time: _____
PATIENT MIDDLE NAME:		Person Completing Form:
PATIENT WEIGHT (IF KNOWN):		Phone Extension:

PRIORITY & COMMENTS

☐ Planned Transfusion Date: _____ Time: _____	☐ **Preadmission Type and Screen** - must complete questions below
☐ Routine	Date of Surgery: _____ Time: _____
☐ STAT	History of Pregnancy in last 3 months? No Yes
Comments:	Transfusion within the last 3 months? No Yes

TESTING REQUESTED

☐ Type and Screen – Required for Transfusion	☐ Direct Antiglobulin Test (DAT)
☐ Confirmatory ABO/RhD	☐ Antibody Screen
☐ ABO/RhD only	☐ Patient RBC Phenotype
☐ Blood Bank Hold, Extra Tube	☐ Other – specify: _____

SPECIAL REQUIREMENTS / PROCESSING (Check all that are required) Note: RBCs/Platelets are Leukocyte-reduced/CMV-safe.

☐ Irradiated or Psoralen-treated	☐ Volume overload (plasma reduce all platelets)	☐ Allergic Rxn (plasma reduced or PAS platelets)	☐ Washed (1st order requires Transfusion Service MD Approval)	☐ Supernatant Removed RBC (Supernatant removed = Plasma depleted; Order for ABO Incompatible Heart Transplant < 2 y.o.)	☐ HbS Neg (Sickle Cell Disease / < 4 months of age)	☐ Rh/K Antigen Selected (Hemoglobinopathy)	☐ Other

BLOOD COMPONENT ORDER (Specify volume or number of units needed)

Red Blood Cells	Volume Needed: _____mL OR _____unit(s)	☐ Reconstituted RBC for manual exchange transfusion: _____mL
Platelets	Volume Needed: _____mL OR ☐ Apheresis	
Plasma	Volume Needed: _____mL OR ☐ Unit(s): _____ (Note: Units ~200-400mL)	
Cryoprecipitate	Volume Needed: _____mL OR ☐ 5-Pool(s): _____ (Note: single cryo ~10mL; 5-pool ~75mL)	

First Specimen Collection		Second Specimen Collection (Confirmatory ABO/RhD)		Labeling Requirements
Date of Collection (mm/dd/yy):	Time of Collection:	Date of Collection (mm/dd/yy):	Time of Collection:	▪ DATE & TIME of collection & TWO SETS of INITIALS are on specimen ▪ DATE & TIME of collection match exactly on specimen & this request ▪ Patient Name & MRN match on: ○ Specimen Label ○ This request form ○ Patient ID band ▪ 2 – Person verification at the bedside after specimen collection. Both individuals have signed this request form and TWO SETS of initials on filled labeled tube(s)
X_____ Person Collecting Specimen		X_____ Person Collecting Specimen		
X_____ 2nd Person Verifying Labeling Requirements		X_____ 2nd Person Verifying Labeling Requirements		