REQUEST FOR BLOOD AND TRANSFUSION TESTING
Transfusion Services Laboratory

Bloodworks Labs
LABORATORY SERVICES

921 Terry Ave, Seattle, WA 98104

☐ **CENTRAL**	**PH.** (206) 689-6525	**FAX** (206) 343-1780
☐ **OVERLAKE**	**PH.** (425) 467-3374	**FAX** (425) 688-5031
☐ **EVERGREEN**	**PH.** (425) 434-4949	**FAX** (425) 899-7524
☐ **SKL**	**PH.** (425) 656-7900	**FAX** (425) 255-0166

PATIENT INFORMATION

HOSPITAL/INSTITUTION			ORDERING PHYSICIAN	DATE
Name on Sample LAST	**FIRST**	**MIDDLE**		
			PERSON COMPLETING REQUEST	CONTACT PHONE
MEDICAL RECORD NUMBER			DIAGNOSIS:	
Social Security Number	Sex (M/F)	Date of Birth (mm/dd/yyyy)	TYPE OF IMPENDING PROCEDURE/SURGERY(if applicable):	

PRIORITY

☐ **Emergency Crossmatched / Testing requested STAT**

☐ **Emergency Uncrossmatched**
(Physician justification required. Specimen required)

☐ **Planned Transfusion**: Date: _____Time: _____

☐ **Routine**-(Release within 4 hrs after receipt of specimen at BW)

☐ **Patient Waiting in clinic (2hr)**

FOR BLOODWORKS USE ONLY

BW TECH	READ-BACK OF PHONE ORDER VERIFIIED BY	ORDER#

APPROVED BY	TIME RECEIVED AT BW

☐ **Patient Profile** To set up BW patient profile only, not for placing component order. (Check applicable boxes below, see back of from)
□ Irradiated □ Leukocyte Reduced □ CMV Negative □ Plasma Reduced □ Washed □ CD38

TESTING REQUESTED

☐ Type and Screen – **Required for Transfusion** (valid for 3 days)	☐ Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin
☐ HOLD specimen (valid for 3 days)	☐ Extended Postnatal Profile (for Baby)
☐ ABO/RhD only	☐ HSCT crossmatch - Recipient (Enter donor information below) (RF12)
☐ Antibody Screen	☐ HSCT crossmatch -Donor (Enter recipient information below) (RF13)
☐ Direct Antiglobulin Test (DAT)	
☐ Prenatal Profile	Name: _____ MRN: _____

SPECIAL REQUIREMENTS / PROCESSING (Check all that are required)

☐ Irradiated	☐ Leukocytes Reduced	☐ CMV Negative (Leukocytes Reduced provided if not available)	☐ Washed (1st order requires BW Transfusion Service MD Approval)	☐ HbS Neg (Sickle Cell Disease / < 4 Months)	☐ Plasma Reduced Platelets

COMPONENTS ORDERED (Indicate number of Units Required)

Red Blood Cells, Leukocytes Reduced	_____ RBCs	☐ **FOR HAEMOBANK CUSTOMERS**: Check if RBCs are only needed if not electronic crossmatch (Remote Allocation) eligible	_____**INFANT RBC DIVIDED** Units held for one patient. Assigned Aliquots (≈30-50 mL)
Plasma	_____Adult(~250mL)	_____Pediatric Plasma (~50mL)	Pooled Plasma (Specify volume needed) _____**L**
Platelets, Leukocytes Reduced	_____ **Adult Dose**		**FOR BLOODWORKS USE ONLY** Trip# / SPECIMEN#
Cryoprecipitate	_____ Adult dose (5 units/pool)	_____ Cryo- Single Unit (~20mL)	
Other (see back of form)			

Specimen Draw for Testing			
Draw Date:	Draw Time:	Comments:	HX ☐ Tech ID: _____ Date: _____ ABO/RhD: _____ Hx of Ab: _____
X_____			Last panel date:
Person Collecting Specimen and performing Positive Patient ID			
X_____			
2nd Person performing Positive Patient ID			

TO REORDER FORMS CALL 425-656-3022
TO RECIPIENT OF FAX:

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Explanation of items on the front of the form

Patient Profile: no current blood/component order, set up BW Patient Profile only with special attributes:

- Check the Patient Profile box to set up a patient profile in the BW computer database to establish required special attributes/modifications (e.g. CMV negative, irradiated, volume reduced, washed) for a particular patient for future blood component orders. This option is provided to allow required special attributes/modifications to be defined for a patient before components are ordered to help ensure future component orders include the correct required special attributes. All future orders will contain these special attributes/modifications even if they are not indicated on the orders. An attribute/modification may be removed from a patient's record only by a specific order from the patient's medical provider to BW to remove the attribute/modification.
- Indicate special attributes/modifications required on the Patient Profile by checking all applicable boxes listed in the Patient Profile box.
- The patient identification information entered into the BW Patient Profile will be exactly as received on this request.

Other:

Write the product name or abbreviation in the "OTHER" box on the front of form.

Indicate the number of units required.

Place a check mark in the appropriate boxes for any required attributes.

The Following “Other” components require type and crossmatch testing:

- **Granulocytes (GRANS):** Must receive Prior Bloodworks approval
- **Red Blood Cells Resuspended, Leukocytes Reduced (~ 500 mL) (RBCR):** Intended for neonatal whole blood exchange only.

The Following “Other" components do not require type and crossmatch testing:

- **Platelets Apheresis, Matched [HLA or Family - (MAP)]:** Must receive Prior Bloodworks approval.
- **Pooled Plasma for Apheresis:** Order by volume (0.5 to 10 L). Specific volume is required.
- **Cryo-Poor Plasma Pooled (CPPP):** Order by volume (0.5 to 10 L). Specific volume is required.

Attributes/Modifications:

- When attributes/modifications are selected with blood component orders, these are added to the BW patient profile.
- All future orders will contain these special attributes/modifications even if they are not indicated on the current orders.
- An attribute/modification may be removed from a patient's record by utilizing the “Patient Profile” section on the front of this form.

Adult Standard Dose:

- Platelets
  - Apheresis Platelets = a platelet count of $\geq 3.0 \times 10^{11}$.
  - Infant platelet dose: RN will need to draw off the dose from an apheresis platelet
- Cryoprecipitate
  - “Standard Dose” is the number of units pooled in each bag to reach a Factor VIII level of at least 400 IU, and a fibrinogen at least 750 mg per dL. Per the Circular of Information, assume 80 IU of Factor VIII and 150 mg of fibrinogen for each unit of Cryoprecipitated AHF (i.e., 400 IU Factor VIII and 750 mg per dL). The standard dose will yield an estimated rise in plasma fibrinogen of 37 mg per dL.

Tests performed in Profiles:

- **Type and Screen:** ABO, Rh, antibody screen. Antibody identification will be reflexively performed for a positive screen to expedite blood if needed
- **Prenatal Profile:** ABO, Rh, antibody screen. Antibody identification if indicated.
- **Extended Postnatal Profile (for Mother) Fetal Bleed Screen to dose Rh immune globulin.** ABO, Rh, antibody screen on mother. Antibody identification and fetal bleed screen if indicated. Sample should be drawn within a few hours post-delivery
- **Extended Postnatal Profile (for Baby):** ABO, RhD, direct antiglobulin test. Antibody identification performed separately if indicated/requested.