

## Transfusion Services Order

Patient Information				
Last Name _____ First Name _____ MI _____ Date of Birth _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Facility Patient ID # _____ Race _____	Transfused or pregnant within last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ <input type="checkbox"/> NA <input type="checkbox"/> Unknown	Diagnosis _____ Medications _____	Received by TS	
Ordering Physician _____ Ordering/Transfusion Facility _____ Facility Address _____ Facility Phone _____	Specimen Requirements: 7 mL Purple Top (EDTA) No Red Top Serum Separator Specimen Collection Date/Time _____ Phlebotomist ID _____			
Testing Requested	Component And Quantity Requested	Special Instructions	Order Status	
<input type="checkbox"/> Type and Crossmatch <input type="checkbox"/> Type and Screen <input type="checkbox"/> Blood Type <input type="checkbox"/> DAT <input type="checkbox"/> Draw and Hold <input type="checkbox"/> RhIG Evaluation <input type="checkbox"/> Additional Crossmatched Units <input type="checkbox"/> Antibody ID <input type="checkbox"/> Titer <input type="checkbox"/> Antibody Screen <input type="checkbox"/> Other _____	_____ Leukoreduced RBC _____ Pediatric Leukoreduced RBC (volume needed _____) _____ Apheresis Platelet(s) _____ Plasma (volume needed _____) _____ Cryoprecipitated, AHF _____ Pediatric Platelet (volume needed _____) _____ Other (specify) _____	<input type="checkbox"/> Irradiated <input type="checkbox"/> Washed* <input type="checkbox"/> CMV Negative <input type="checkbox"/> Specific Hct* <input type="checkbox"/> Volume Reduced <input type="checkbox"/> Autologous <input type="checkbox"/> HLA Matched <input type="checkbox"/> Directed <input type="checkbox"/> Sickle Cell Negative *Consult with Transfusion Service for Availability	<input type="checkbox"/> STAT <input type="checkbox"/> ASAP <input type="checkbox"/> Routine Date/Time needed _____	BBID Sicker
Pretransfusion Criteria (Indicate all that apply)				
<b>RED BLOOD CELLS</b> Current Hgb or HCT _____ <input type="checkbox"/> Pre-Surgery (anemia) <input type="checkbox"/> Hemoglobin (≤ 7 g/dL or Hematocrit ≤ 24%) <input type="checkbox"/> Symptomatic anemia <input type="checkbox"/> Active bleeding/Acute blood loss <input type="checkbox"/> Other (specify) _____	<b>PLATELETS</b> Current Platelet Count _____ <input type="checkbox"/> Platelet count of 20,000/uL or less (outpatient) <input type="checkbox"/> Platelet count of 10,000/uL or less (inpatient) <input type="checkbox"/> Platelet count of < 50,000/uL, bleeding or surgery in < 24 hours <input type="checkbox"/> Platelet dysfunction and bleeding/ planned surgery <input type="checkbox"/> Platelet count < 50,000 uL after RBC transfusion due to blood loss <input type="checkbox"/> Other (specify) _____	<b>PLASMA</b> PT _____ PTT _____ INR _____ <input type="checkbox"/> Patient bleeding or preoperative with an INR > 2.0 or PT/PTT > 1.5 <input type="checkbox"/> Coag Factor deficiencies planned/ surgery <input type="checkbox"/> Rapid reversal of Warfarin effect <input type="checkbox"/> TTP <input type="checkbox"/> Other (specify) _____	<b>CRYOPRECIPITATED, AHF</b> Fibrinogen Level _____ <input type="checkbox"/> Diffuse microvascular bleeding and fibrinogen < 100 mg/dL <input type="checkbox"/> Hemostasis required (Other therapies not available or working) <input type="checkbox"/> Massive transfusion <input type="checkbox"/> Fibrin glue	HCLL Accession #