

**BLOOD BANK REQUISITION**

All specimens must be signed and dated.

Director: Ed Thornborrow, MD, PhD UCSF Blood Bank (M-501) Fax 3-1316 Phone 3-1313

UCSF Mission Bay Blood Bank (M2348) Fax 6-4703 Phone 6-1404 • UCSF Mt. Zion Blood Bank (B235) Fax 5-7780 Phone 5-7791

All fields must be completed if requesting blood products

Ordering Provider _____ Provider # _____ (Required)

Provider is a(n): ☐ Attending ☐ Resident/Fellow ☐ Allied Health Practitioner
(attending info. req'd.) (Incl. attending info. if req'd.)Attending Physician _____ UCSF Provider # _____ (Required)
(Print Name)Copy to: _____ UCSF Provider # _____ (Required)
(Print Name)

Authorizing Provider Signature: _____ (Required)

LOC/FLOOR _____ EXT _____

DATE/TIME TO BE TRANSFUSED _____

☐ ROUTINE (4 hr.) ☐ STAT (1 hr.)**PREPARE CLINIC USE ONLY:**

DATE/TIME OF SURGERY _____

SURGICAL PROCEDURE _____

Pregnant/Transfused in previous 3 months?

☐ Yes ☐ No ☐ UnknownIs patient scheduled to receive blood products prior to surgery? ☐ Yes ☐ No

Verified by _____ Full name (required)

☐ Patient has arranged for autologous/designated donor transfusion. Donor Center _____**BLOOD BANK USE ONLY**

ACC#: _____

SPECIMEN DATE: _____

DIAGNOSIS / ICD 9 CODE:
(Inpatient/Outpatient)

MR NUMBER

PT. NAME

BIRTHDATE

LOCATION

DATE

BLOOD BANK USE ONLY

- ☐ COMP. HX CHECK: ABO/Rh ☐ Need Check Specimen ☐ ABO Confirmation Completed

SPECIAL REQUIREMENTS CHECK:

- ☐ No Special Req. on file ☐ Washed
☐ Irradiation ☐ Vol Red
☐ CMV Negative ☐ Hgb S Neg.
☐ Other: _____

☐ BMT ABO Requirements

RBC _____ FFP _____ PLT _____

COMMENTS☐ Antibodies: _____

Most recent labs as of _____

PLATELET COUNT _____ X10⁹/mL

PT _____ INR _____ Fib _____

DATE/TIME: _____ INITIAL: _____

NOTIFICATION BY: _____**PERSON NOTIFIED:** _____**Date:** _____ **Time:** _____☐ BLOOD READY Loc / Ext. _____☐ NEEDS / SPECIMEN☐ OTHER: _____**ROUTINE TESTS**

Specimen Requirements Table on back of form

- ☐ ABO/Rh and Antibody Screen (Type & Screen)
☐ INFANT < 4 MONTHS
☐ PRENATAL ☐ POST PARTUM

☐ CHECK SPECIMEN
(CONFIRMS ABO/Rh)☐ HOLD SPECIMEN ☐ CORD HOLD
(NO TESTS PERFORMED)**MISCELLANEOUS TESTS**

- ☐ ABO GROUPING
☐ Rh TYPING
☐ ANTIBODY SCREEN
(INDIRECT ANTI-HUMAN GLOBULIN TEST)
☐ DIRECT ANTI-HUMAN GLOBULIN TEST
☐ CORD BLOOD TESTING (ABO, Rh, DAT)
☐ ANTIGEN TYPING
☐ Rh PHENOTYPE
☐ OTHER (SPECIFY) _____
☐ ANTIBODY TITER (PRENATAL)
☐ ISO HEMAGGLUTININ TITER (ABO)
☐ KIDNEY TRANSPLANT ONLY
DONOR BLOOD TYPE _____
☐ PEDI-BMT
☐ POTENTIAL BONE MARROW DONOR #: _____
☐ ECMO SET-UP
☐ Age: _____ ☐ Weight: _____
☐ OTHER _____

PRODUCTS REQUESTED☐ CROSS MATCH

PRODUCTS	APPROX. mL PER UNIT	No. UNITS
RED BLOOD CELLS (RBC)	300	
DIVIDED RBC (Pedi)	75	
DIVIDED RBC (Syringe)	by vol. 50mL Max	

PRODUCTS NEEDED FOR:☐ Bleeding ☐ Procedure

PRODUCTS	APPROX. mL PER UNIT	No. UNITS
FRESH FROZEN PLASMA	200	
FRESH FROZEN PLASMA, DIVIDED (Pedi)	75	
PLATELET PHERESIS (Adult dose)	300	
PLATELET PHERESIS DIVIDED (Pedi)	150	
PLATELET PHERESIS DIVIDED (Quad)	75	
PLATELET PHERESIS DIVIDED (Syringe)	Max 50mL	

CRYOPRECIPITATE DOSE (Adult dose = 10 units)	150	
CRYOPRECIPITATE DOSE (Pool of 5 Units)	75	
CRYOPRECIPITATE (Individual unit)	15	
Rh (D) IMMUNE GLOBULIN	300µg dose	

OTHER (Specify): _____

SPECIAL REQUIREMENTS**All Products are Leukoreduced.**

Special Requirements must meet
Transfusion Service Guidelines
(<http://labmed.ucsf.edu/labmanual/mftlng-mtzn/test/info/toc.html#TransfusionService>)

PATIENT REQUIRES:

- ☐ Irradiated product
☐ CMV Negative Product
Note: CMV testing will be initiated automatically if patient status is unknown and not already ordered.
☐ Washed Red Blood Cells
☐ Volume reduced platelets
☐ Other _____

BB CHECK

EMERGENCY REQUEST

THIS PATIENT REQUIRES EMERGENCY TRANSFUSION DUE TO ACUTE BLEEDING. PLEASE RELEASE BLOOD PRODUCTS INDICATED PRIOR TO COMPLETION OF STANDARD COMPATIBILITY TESTING.

Signature _____

M.D. # _____

Must call Blood Bank to initiate release**BLOOD BANK USE ONLY**

LOC _____ Ordered by: _____

READ BACK & CONFIRMED BY: _____

Date: _____ Time: _____

TEST	Patient age	Preferred Volume (EDTA = purple top)*	Minimum Volume (EDTA= purple top)*
Type and Screen &/or Crossmatch			
	Infant < 4 mo	Full microtainer**	Full microtainer**
	Peds 4 mo – 1 yr	3 mL	1 mL
	Peds 1 - 18 yrs	3-6 mL (3 mL tube OK for small children)	3 mL
	> 18 yrs	6 mL	5 mL
Check specimen			
	Infant < 4 mo	Full microtainer**	Full microtainer**
	Any patient > 4 mo	3 mL	1 mL

* Additional sample may be required for antibody identification or further testing

** A full microtainer = 0.8 mL

All specimen tubes must be signed and dated