UCSF Health

BLOOD PRODUCT PICK-UP SLIP

Use ONLY when APeX-generated pickup slip is not available.

This form must be completed by the provider or nurse requesting blood products. Staff MUST provide this form at window if being picked up from the Blood Bank. For delivery by tube/robot/courier fax to:

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

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

	COMPONENTS	APPROX. ML PER UNIT	NUMBER OF UNITS / Volume
Red Blood Cells	RED BLOOD CELLS (RBC)	300	
	DIVIDED RBC (Quad)	75	
	DIVIDED RBC (Syringe)	by volume	
	WASHED RED CELLS	250	
FFP	FRESH FROZEN PLASMA	200	
	FRESH FROZEN PLASMA (Pedi)	75	
Platelets	PLATELET PHERESIS (Adult)	300	
	DIVIDED PLATELET PHERESIS (Pedi)	150	
	DIVIDED PLATELET PHERESIS (Quad)	50-75	
	PLATELET PHERESIS (Syringe)	By volume	
Cryo	CRYOPRECIPITATE DOSE (10 UNITS)	150	
	CRYOPRECIPITATE DOSE (5 UNITS)	75	
	CRYOPRECIPITATE (EACH)	15	
Other	Rh (D) IMMUNE GLOBULIN	300 µg/vial	
	GRANULOCYTES	300 mL	

ATTESTATION

SPECIAL REQUIREMENTS:

- ☐ None
- ☐ Irradiation
- ☐ CMV Negative
- ☐ Washed
- ☐ Volume Reduced
- ☐ Other: _____

☐ **I have verified provider order to transfuse AND provider order for special requirements.**

Requested by _____ RN

Phone#: _____

Date: _____ Time: _____

DELIVERY

Deliver products to: _____

Deliver by:

- ☐ Floor Pick up
- ☐ Tube
- ☐ Robot
- ☐ BB Courier
- ☐ Products in Cooler (authorized locations)

Tube delivery confirmation:

Received by _____

Date: _____ Time: _____

Blood Bank Use Only: File/Unit/Label Check	
ABO / Rh Confirmed	
Meets Irradiation Requirements	
Meets CMV Requirements	
Meets Ag/Ab and Special Attribute Requirements	
Meets BMT Requirements	
Cooler I.D. if applicable	
Issued by (initials) & Time Stamp	