Denver Health Medical Center

Department of Pathology and Laboratory Services

777 Bannock Street, Denver, Colorado 80204 303-602-5261

2 5 4 2

TRANSFUSION SERVICE DOWNTIME

Transfusion Service Requisition

☐ Routine ☐ STAT ☐ Add On

Date: Location:

Sex:

Name:

Birthdate/Age:

Medical Record Number:

☐ FOR OR: _____ _____
Date of Surgery OR Room Number

☐ FOR Hem/Onc Infusion: _____
Date of Transfusion

Time of Order:

Pregnancies: G_____P_____ AB_____

Transfusion Specimens for Crossmatch

Required: Yellow BB armband and Pink Top Tube

- Patients full name, MRN, DOB
- Yellow BB Armband Sticker
- Full Date & Time
- Signature/initials of who drew the specimen

Improperly labeled specimens will not be accepted.

Diagnosis:

Attending Physician:_____Professional #_____

Requesting Physician:_____Professional #_____

***Component Requests Not Meeting Transfusion Guidelines May Require Pathology Consult**

X	TESTS
	TYPE AND SCREEN (Blood Type and Aby Screen) Special Transfusion Armband, Pink Top Tube If Aby Screen is positive, an Aby ID is performed.
	BLOOD TYPE ONLY (ABO & RH)
	PRENATAL TYPE AND SCREEN (Blood Type and Aby Screen) If Aby Screen is positive, an Aby ID is performed. An Aby Titer will be performed on significant antibodies.
	RH IMMUNE GLOBULIN EVALUATION (Pink top tube) **(RH Immune Globulin Provided by Pharmacy)** ☐ **Antepartum RHIG Eval** Gestation:_____Weeks Includes Blood Type and Antibody Screen ☐ **Postpartum RHIG Eval** Includes Blood Type and Fetal Screen. If Fetal Screen is positive, includes Kleihauer-Betke.
	CORD BLOOD TESTING Mother's Name:_____ Mother's MRN:_____
	TYPE AND HOLD (Pav C only)
	Other:

QTY	COMPONENTS
	LEUKOREDUCED RED BLOOD CELLS ☐ Irradiated (Call Blood Bank)
	PLASMA
	***PLATELET PHERESIS (Leukoreduced)** ☐ Irradiated (Call Blood Bank)
	***CRYOPRECIPITATE**
	PEDIATRIC ALIQUOT Neonate Syringe Volume (ml):_____ Units Required (units or ml):_____ ☐ RBC ☐ Platelet
	TISSUE RETRIEVAL **Amniograft? Yes No** Type: Lot #:
	BONE FLAP ☐ Storage ☐ Retrieval ☐ Left ☐ Right