Pre-Watchman Lab Order*

Patient Name: _____ DOB: _____

Address: _____

Home #: _____ Cell #: _____

Date Lab Work Due: Monday- _____ 06:30 AM - 03:30 PM

St. Joseph's Outpatient Lab (across Mercy Blvd from Hospital)

Plaza A, Building 3
11706 Mercy Blvd
Savannah, GA 31419
Phone: 912.819.4212
Fax: 912.819.3620

Lab Orders Use Account V_____

- ○ **All tests listed below**
- ○ Type and Screen
- ○ CBC
- ○ BMP
- ○ PT
- ○ PTT
- ○ Albumin
- ○ 4 units PRBC
- ○ Type Confirm (call BB at 2865 to see if needed)

Has the patient had a transfusion in the last 3 months?	Yes	No	UNK
Has patient had a pregnancy within the last 3 months?	Yes	No	
Does this patient require irradiated blood products? (Chemo)	Yes	No	
Does this patient have Sickle Cell Disease?	Yes	No	

Diagnosis codes: _____

Ordering Provider: _____ Date: _____

***A copy of this order must accompany specimens to the Blood Bank.**