UCHealth
University of Colorado Hospital
Clinical Laboratory-Blood Bank

DOWNTIME LAB REQUESTS
TRANSFUSION SERVICES

Patient's Full Name Place Sticker _____

MRN # _____

Location _____

Location Phone # _____

Location Tube Station # _____

Ordering Provider Name & # _____

Collection time: _____

Collection date: _____

Collected by: _____

TWO PEOPLE MUST IDENTIFY AND INITIAL ALL BLOOD BANK SPECIMENS

Blood Bank tube stations: 531 and 631

PREPARE RBCs for TRANSFUSION

Number of Units ☐ 1 Unit ☐ 2 Units ☐ Other _____

Indication ☐ Active bleeding ☐ Peri-Op ☐ Anemia ☐ Other _____

Special Requirement ☐ Irradiated ☐ CMV neg ☐ HgbS neg

Donor source ☐ Directed Donor ☐ Autologous

Liver Transplant Risk Level ☐ Low 5 units ☐ Medium 10 Units ☐ High 20 units

PREPARE PLATELETS for TRANSFUSION

Number of Units ☐ 1 Unit ☐ 2 Units

Indication ☐ Plt Dysfunction ☐ Peri-Op ☐ Other _____

Special Requirement ☐ Irradiated ☐ CMV neg ☐ PRA neg ☐ HLA Matched

PREPARE PLASMA for TRANSFUSION

Number of Units ☐ 1 Unit ☐ 2 Units ☐ Other _____

Indication ☐ Active bleeding ☐ DIC ☐ Elevated INR ☐ Other _____

Special Requirements ☐ Other (specify) _____

PREPARE CRYOPRECIPTATE for TRANSFUSION

Pooled vs Single ☐ Pack pooled cryo ☐ Single individual cryo

Number of Units ☐ 1 Unit ☐ 2 Units ☐ Other _____

Indication ☐ Low fibrinogen ☐ TEG abnormal ☐ Other _____

BLOOD BANK TESTING-PINK TOP TUBE

LAB276 ☐ Type and Screen

LAB4431 ☐ Antibody Titer ☐ IgG ☐ IgM
LAB895 ☐ ABO/RH Type
LAB278 ☐ Antibody Screen
LAB274 ☐ Direct Antiglobulin Test (DAT)

OBSTETRIC SPECIFIC ORDERS

LAB3494 ☐ RhoGAM Evaluation
☐ rho D immune globulin (HYPERHO S/D) injection
LAB3453 ☐ Blood Bank Hold Sample
LAB3669 ☐ Convert Blood Bank Hold to Type and Screen
LAB4546 ☐ Fetal Screen
☐ Prepare RBC Intrauterine Transfusion

NEONATAL SPECIFIC ORDERS

LAB4932 ☐ Cord Blood Workup (ABO/Rh & DAT)
LAB3496 ☐ Newborn Transfusion Evaluation
Is infant <800g or <26 wks? ☐ Yes ☐ No

Tranfusion Orders (Newborn Transfusion Evaluation is required)

☐ Red Blood Cells in mL Quantity_____
☐ Plasma in mL Quantity_____
☐ Platelets in mL Quantity_____
☐ Single individual cryo ☐ 1 Unit

☐ Double Volume Exchange Transfusion Quantity_____

TRANSFUSION REACTION INVESTIGATION

LAB893 ☐ Mark symptoms on the back of this form and bring the blood product and pink top tube to Blood Bank STAT with tranfused unit and tubing

FOR ALL EMERGENT (TRAUMA), MASSIVE TRANSFUSION PROTOCOL, & OBSTETRICAL MTP ORDERS, CALL BLOOD BANK 8-4444 IMMEDIATELY

Because a delay in transfusion could jeopardize the patient's life, I authorize the release of blood before compatibility studies are complete.

_____MD Signature required

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Patient Consent to Receive Blood Product Signed and in Medical Record

We certify that the information on the Transfusion Tag has been checked and is identical to the information to the recipient hopital ID Bracelet and to the Blood Unit that it is attached to.

_____RN/MD
Transfusion Started by

_____RN/MD
Double Checked by

Note: All blood components should be transfused within 4 hours. If not started immediately, return directly to blood bank within 20 minutes.

TO BE COMPLETED BY TRANSFUSIONIST

	Date	Time	B.P.	Temp	Pulse	Resp
Vitals at Time Started						
Vitals at 15 minutes						
Vitals at completion						

Amount Given: ☐ Unit completely transfused ☐ Partial unit transfused, approximate volume_____ mL

INSTRUCTIONS FOR TRANSFUSION REACTION

1. STOP TRANSFUSION IMMEDIATELY
2. KEEP IV OPEN WITH 0.8% SALINE
3. NOTIFY ATTENDING PHYSICIAN
4. NOTIFY BLOOD BANK
5. VERIFY THAT THE INFORMATION ON TRANSFUSION RECORD AND PATIENT ARM BANDS AGREE. NOTIFY BLOOD BANK OF ANY DISCREPANCIES IMMEDIATELY
6. OBTAIN POST TRANSFUSION SAMPLE STAT DRAWN IN PINK TOP EDTA
7. HAND DELIVER SAMPLE AND UNIT WITH BLOOD BAG AND ALL ATTACHED LINES AND SOLUTIONS

CLINCAL SIGNS AND SYMPTOMS OF A TRANSFUSION REACTION

___ CHILLS
___ SHOCK
___ FEVER
___ URTICARIA
___ HYPOTENSION
___ HYPERTENSION
___ TACHYCARDIA
___ BRACHYCARDIA
___ DYSPNEA
___ FLUSHING
___ OLIGURIA
___ OOZING FROM WOUND/VENIPUNCTURE
___ ANURIA
___ PRURITIS
___ COUGH
___ HEADACHE
___ PINK SPUTUM
___ RESTLESSNESS
___ HEMOGLOBINEMIA
___ HEMOGLOBINURIA
___ SEVERE LOW BACK PAIN
___ PAIN AT INFUSION SIGHT, ___ CHEST OR FLANK
___ NAUSEA/ VOMITING

PRE-PROCEDURE PATIENT BLOOD BANK INFORMATION

Date and Name of Procedure _____/_____ **Clinic/Phone #** _____/_____

Name of Ordering Physician/Pager # _____/_____

Blood Bank governing agencies allow a specimen to be drawn for Pre-Transfusion testing more than 3 days prior to the anticipated transfusion if:

1. The patient has not received any blood transfusions within the preceding 3 months **AND**
2. *For female patients,* the patient has not been pregnant within the preceding 3 months.

If you meet these requirements and it is not more than 30 days before your procedure, a Blood Bank specimen will be drawn to expedite the process involved in having blood available in the event you should need a transfusion.

For the Transfusion Service Record, please verify that the following information is TRUE by signing the following statements:

1. To the best of my knowledge, I have not received any transfusions of blood products within the previous three (3) months.

_____ _____
Patient / Guardian Signature *Date*

2. ***(For Female patients only)*** To the best of my knowledge, I have not been pregnant within the previous three (3) months.

_____ _____
Patient / Guardian Signature *Date*