Clear Fields

LIFESouth CommunityBloodCenters

Request for Transfusion Services

Sample Requirements: 10 to 15 mL of blood collected in three EDTA red- or purple-top tubes; at least one purple-top tube must be submitted.

Referral Information

Contact Name:	Phone:	Fax:
Hospital/Facility:	City/State:	
Date/Time Requested:	Date/Time Needed:	

Urgency: ☐STAT ☐ROUTINE/ASAP
(For STAT requests additional fees apply)

Patient Information/History (or apply addressograph)

Patient Name: Last First Middle Initial		
Sex: ☐M ☐F	Physician:	
DOB:	Patient ID or MR#:	
Race:	Does patient have history of sickle cell anemia? ☐No ☐Yes	
Diagnosis:		
Medications (attach additional documentation if necessary):		
Lab Values		
ABO/Rh (if known):	Current Hgb/Hct:	Current platelet count:
Transfusion History		
Has patient ever been transfused? ☐No ☐Yes	Has patient been transfused within last 3 months? ☐No ☐Yes	
Products previously transfused (check all that apply): ☐RBC; date:	☐Platelets; date:	☐Plasma; date:
Known RBC antibodies? ☐No ☐Yes; specify:		
Pregnancy History ☐N/A		
Number of previous pregnancies:	Currently pregnant? ☐No ☐Yes	Received Rhlg? ☐No ☐Yes; date:

Reason for Submission/Component Information

Blood Component **Quantity Needed**	**Special Request(s)**
☐ Red Blood Cells ☐ Platelets ☐ FFP ☐ Type & Screen only (no units) ☐ Other; specify:	
Phlebotomist(s) Printed Name or ID:	
Phlebotomist(s) Signature:	Collection Date(s)/Time(s):
Phlebotomist(s) Printed Name or ID:	
Phlebotomist(s) Signature:	Collection Date(s)/Time(s):

For Laboratory Use Only	
Patient History/Comments:	
Time sample received in IRL: : ☐am ☐pm	Previous record check performed by: Date:

Reviewed by:	Date:

FL-IRL: FAX COMPLETED FORM TO (352) 334-1029 • CONFIRM FAX RECEIVED AT (352) 334-1028

Atlanta Area: FAX COMPLETED FORM TO (888) 316-2381 • CONFIRM FAX RECEIVED AT (844) 329-0601