Clear Fields

Request for Special Types of Red Blood Cells

Use this form to request components with special requirements with no patient specimen submitted.
*For orders where a patient specimen will be sent, see **HPM.1.2, Request Immunohematology Services.***
For stock orders, use the Daily Blood Inventory/Order Report form.

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 (Complete section or apply addressograph. Include all available information.)

Patient Name: _____ _____ _____
Last First Middle Initial

Sex: ☐ **M** ☐ **F**	Patient ABO/Rh:	Current Hgb/Hct:
DOB:	Known Antibodies: ☐No ☐Yes; specify:	
Patient ID or MR#:	Ordering Physician:	
Race:	Physician Contact Number:	
Reason for Special Request/Diagnosis (attach additional documentation if necessary):		

Special Request(s)

Number of units needed: _____ *AC Type (optional):* ☐*Any* ☐*AS-1* ☐*CPDA-1* ☐*Other:* _____

☐ Sickle Cell Negative ☐ Irradiated ☐ Pediatric Units/Aliquots ☐ Leukoreduced (CMV safe)

☐ Washed *(LifeSouth Medical Director approval required)* *LifeSouth approval of washing:* Approved By/Date: _____

☐ Reconstituted; Hematocrit: _____ % (± 5%) ☐ Red Blood Cells ≤ _____ days old

Total Volume: _____ mL ☐ CMV negative

☐ Confirmed Serologically ☐ Historically Negative (antigens to be confirmed at your facility) ☐ N/A

Circle Negative Antigens:

C E K c e Jk^a Jk^b Fy^a Fy^b M N S s Le^a Le^b

Other: _____

For Laboratory Use Only	
Testing performed by: ☐ GA-IRL ☐ FL-IRL	Accession Number:
Patient History/Comments:	☐SAU Hx ☐SAU Conf ☐Fresh ☐Leukoreduced ☐Irradiated ☐CMV- ☐# Units filled ☐HbS- ☐Vol indicated Pending # Units: _____ Reviewed/Verified by: _____
Time sample received in IRL:	