



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: <input type="checkbox"/> M <input type="checkbox"/> F	Patient ABO/Rh:	Current Hgb/Hct:
DOB:	Known Antibodies: <input type="checkbox"/> No <input type="checkbox"/> 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): <input type="checkbox"/> Any <input type="checkbox"/> AS-1 <input type="checkbox"/> CPDA-1 <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Sickle Cell Negative	<input type="checkbox"/> Irradiated	<input type="checkbox"/> Pediatric Units/Aliquots
<input type="checkbox"/> Leukoreduced (CMV safe)		
<input type="checkbox"/> Washed (LifeSouth Medical Director approval required) LifeSouth approval of washing: Approved By/Date: _____		
<input type="checkbox"/> Reconstituted; Hematocrit: _____ % (\pm 5%)	<input type="checkbox"/> Red Blood Cells \leq _____ days old	
Total Volume: _____ mL <input type="checkbox"/> CMV negative		
<input type="checkbox"/> Confirmed Serologically	<input type="checkbox"/> Historically Negative (antigens to be confirmed at your facility)	<input type="checkbox"/> 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: <input type="checkbox"/> GA-IRL <input type="checkbox"/> FL-IRL	Accession Number:
Patient History/Comments:	<input type="checkbox"/> SAU Hx
	<input type="checkbox"/> SAU Conf
	<input type="checkbox"/> Fresh
	<input type="checkbox"/> Leukoreduced
<input type="checkbox"/> Irradiated	<input type="checkbox"/> CMV-
<input type="checkbox"/> # Units filled	<input type="checkbox"/> HbS-
<input type="checkbox"/> Vol indicated	
Pending # Units: _____	
Reviewed/Verified by: _____	
Time sample received in IRL:	