



Center Information:

Subcenter:

### Transfusion Services Order

Patient Information			
Last Name _____ First Name _____ MI _____ Date of Birth _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Facility Patient ID # _____ Race _____	Transfused or pregnant within last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ <input type="checkbox"/> NA <input type="checkbox"/> Unknown	Diagnosis _____ Medications _____	
Ordering Physician _____ Ordering/Transfusion Facility _____ Facility Address _____ Facility Phone _____	<b>Specimen Requirements:</b> 7 mL Purple Top (EDTA) No Red Top Serum Separator	<b>Current Sample</b>	<b>Check Sample (if applicable)</b>
	<b>Collection Date/Time</b>		
	<b>Phlebotomist ID</b>		
Testing Requested	Component And Quantity Requested	Special Instructions	Order Status
<input type="checkbox"/> Type and Crossmatch <input type="checkbox"/> Type and Screen <input type="checkbox"/> Blood Type <input type="checkbox"/> DAT <input type="checkbox"/> Draw and Hold <input type="checkbox"/> RhIG Evaluation <input type="checkbox"/> Additional Crossmatched Units <input type="checkbox"/> Antibody ID <input type="checkbox"/> Titer <input type="checkbox"/> Antibody Screen <input type="checkbox"/> Other _____	_____ Leukoreduced RBC _____ Pediatric Leukoreduced RBC (volume needed _____) _____ Apheresis Platelet(s) _____ Plasma (volume needed _____) _____ Cryoprecipitated, AHF _____ Pediatric Platelet (volume needed _____) _____ Other (specify) _____	<input type="checkbox"/> Irradiated <input type="checkbox"/> Washed* <input type="checkbox"/> CMV Negative <input type="checkbox"/> Specific Hct* <input type="checkbox"/> Volume Reduced <input type="checkbox"/> Autologous <input type="checkbox"/> HLA Matched <input type="checkbox"/> Directed <input type="checkbox"/> Sickle Cell Negative *Consult with Transfusion Service for Availability	<input type="checkbox"/> STAT <input type="checkbox"/> ASAP <input type="checkbox"/> Routine Date/Time needed _____
Pretransfusion Criteria (Indicate all that apply)			
<b>RED BLOOD CELLS</b> Current Hgb or HCT _____ <input type="checkbox"/> Pre-Surgery (anemia) <input type="checkbox"/> Hemoglobin ( $\leq 7$ g/dL or Hematocrit $\leq 24\%$ ) <input type="checkbox"/> Symptomatic anemia <input type="checkbox"/> Active bleeding/Acute blood loss <input type="checkbox"/> Other (specify) _____	<b>PLATELETS</b> Current Platelet Count _____ <input type="checkbox"/> Platelet count of 20,000/uL or less (outpatient) <input type="checkbox"/> Platelet count of 10,000/uL or less (inpatient) <input type="checkbox"/> Platelet count of $< 50,000/uL$ , bleeding or surgery in $< 24$ hours <input type="checkbox"/> Platelet dysfunction and bleeding/ planned surgery <input type="checkbox"/> Platelet count $< 50,000$ uL after RBC transfusion due to blood loss <input type="checkbox"/> Other (specify) _____	<b>PLASMA</b> PT _____ PTT _____ INR _____ <input type="checkbox"/> Patient bleeding or preoperative with an INR $> 2.0$ or PT/PTT $> 1.5$ <input type="checkbox"/> Coag Factor deficiencies planned/ surgery <input type="checkbox"/> Rapid reversal of Warfarin effect <input type="checkbox"/> TTP <input type="checkbox"/> Other (specify) _____	<b>CRYOPRECIPITATED, AHF</b> Fibrinogen Level _____ <input type="checkbox"/> Diffuse microvascular bleeding and fibrinogen $< 100$ mg/dL <input type="checkbox"/> Hemostasis required (Other therapies not available or working) <input type="checkbox"/> Massive transfusion <input type="checkbox"/> Fibrin glue

Received by TS

BBID Sicker

HCLL Admission #

These pretransfusion criteria are based on current evidence-based medical guidelines. Transfusion outside of these parameters is at the discretion of the ordering physician and should be based on the patient's clinical signs and symptoms. Medical Director consultation is available upon request.