



Center Information: Blood Systems Laboratories
Subcenter: BSL-Immunohematology Reference Laboratory
 2424 W. Erie Drive
 Tempe, AZ 85282

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 _____	Received by TS	
Ordering Physician _____ Ordering/Transfusion Facility _____ Facility Address _____ Facility Phone _____	Specimen Requirements: 7 mL Purple Top (EDTA) No Red Top Serum Separator Specimen Collection Date/Time _____ Phlebotomist ID _____			
Testing Requested	Component And Quantity Requested	Special Instructions	Order Status	BBID Sticker
<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)				HCLL Accession #
RED BLOOD CELLS Current Hgb or HCT _____ <input type="checkbox"/> Pre-Surgery (anemia) <input type="checkbox"/> Hemoglobin (≤ 7 g/dL or Hematocrit ≤ 24%) <input type="checkbox"/> Symptomatic anemia <input type="checkbox"/> Active bleeding/Acute blood loss <input type="checkbox"/> Other (specify) _____	PLATELETS 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) _____	PLASMA 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) _____	CRYOPRECIPITATED, AHF 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	

eTS 003 (Rev. 7) SVC010 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.