UCSF Health

BLOOD BANK REQUISITION

All specimens must be signed and dated.

Director: Ed Thornborrow, MD, PhD UCSF Blood Bank (M-501) Fax 3-1316 Phone 3-1313
UCSF Mission Bay Blood Bank (M2348) Fax 6-4703 Phone 6-1404 • UCSF Mt. Zion Blood Bank (B235) Fax 5-7780 Phone 5-7791

MR NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

All fields must be completed if requesting blood products

Ordering Provider _____ Provider # ___ ___ ___ ___ ___ (Required)

Provider is a(n): ☐ Attending ☐ Resident/Fellow (attending info. req'd.) ☐ Allied Health Practitioner (Incl. attending info. if req'd.)

Attending Physician _____ (Print Name) UCSF Provider # ___ ___ ___ ___ ___ (Required)

Copy to: _____ (Print Name) UCSF Provider # ___ ___ ___ ___ ___ (Required)

Authorizing Provider Signature: _____ (Required)

LOC/FLOOR _____ EXT _____

DATE/TIME TO BE TRANSFUSED _____

☐ ROUTINE (4 hr.) ☐ **STAT** (1 hr.)

PREPARE CLINIC USE ONLY:

DATE/TIME OF SURGERY _____

SURGICAL PROCEDURE _____

Pregnant/Transfused in previous 3 months?
☐ Yes ☐ No ☐ Unknown

Is patient scheduled to receive blood products prior to surgery? ☐ Yes ☐ No

Verified by _____ Full name (required)

☐ Patient has arranged for autologous/designated donor transfusion. Donor Center _____

BLOOD BANK USE ONLY

ACC#: _____

SPECIMEN DATE: _____

DIAGNOSIS / ICD 9 CODE: (Inpatient/Outpatient)

ROUTINE TESTS

Specimen Requirements Table on back of form

☐ ABO/Rh and Antibody Screen (Type & Screen)
☐ INFANT < 4 MONTHS
☐ PRENATAL ☐ POST PARTUM

☐ CHECK SPECIMEN (CONFIRMS ABO/Rh)

☐ HOLD SPECIMEN ☐ CORD HOLD (NO TESTS PERFORMED)

MISCELLANEOUS TESTS

☐ ABO GROUPING
☐ Rh TYPING
☐ ANTIBODY SCREEN (INDIRECT ANTI-HUMAN GLOBULIN TEST)
☐ DIRECT ANTI-HUMAN GLOBULIN TEST
☐ CORD BLOOD TESTING (ABO, Rh, DAT)
☐ ANTIGEN TYPING
☐ Rh PHENOTYPE
☐ OTHER (SPECIFY) _____
☐ ANTIBODY TITER (PRENATAL)
☐ ISO HEMAGGLUTININ TITER (ABO)
☐ KIDNEY TRANSPLANT ONLY
DONOR BLOOD TYPE _____
☐ PEDI-BMT
☐ POTENTIAL BONE MARROW DONOR #: _____
☐ ECMO SET-UP
☐ Age: _____ ☐ Weight: _____
☐ OTHER _____

PRODUCTS REQUESTED

☐ CROSS MATCH

	PRODUCTS	APPROX. mL PER UNIT	No. UNITS
RED CELLS	RED BLOOD CELLS (RBC)	300	
	DIVIDED RBC **(Pedi)**	75	
	DIVIDED RBC **(Syringe)**	by vol. 50mL Max	

PRODUCTS NEEDED FOR:
☐ Bleeding ☐ Procedure

	PRODUCTS	APPROX. mL PER UNIT	No. UNITS
FROZEN PLASMA	FRESH FROZEN PLASMA	200	
	FRESH FROZEN PLASMA, DIVIDED **(Pedi)**	75	
PLATELETS	PLATELET PHERESIS **(Adult dose)**	300	
	PLATELET PHERESIS DIVIDED **(Pedi)**	150	
	PLATELET PHERESIS DIVIDED **(Quad)**	75	
	PLATELET PHERESIS DIVIDED **(Syringe)**	Max 50mL	
OTHER / CRYO	CRYOPRECIPITATE DOSE (Adult dose = 10 units)	150	
	CRYOPRECIPITATE DOSE (Pool of 5 Units)	75	
	CRYOPRECIPITATE (Individual unit)	15	
	Rh (D) IMMUNE GLOBULIN	300µg dose	
	OTHER (Specify):		

SPECIAL REQUIREMENTS

All Products are Leukoreduced.

Special Requirements must meet Transfusion Service Guidelines (http://labmed.ucsf.edu/labmanual/mftlng-mtzn/test/info/toc.html#TransfusionService)

PATIENT REQUIRES:

BB CHECK

☐ Irradiated product
☐ CMV Negative Product
Note: CMV testing will be initiated automatically if patient status is unknown and not already ordered.
☐ Washed Red Blood Cells
☐ Volume reduced platelets
☐ Other _____

EMERGENCY REQUEST

THIS PATIENT REQUIRES EMERGENCY TRANSFUSION DUE TO ACUTE BLEEDING. PLEASE RELEASE BLOOD PRODUCTS INDICATED PRIOR TO COMPLETION OF STANDARD COMPATIBILITY TESTING.

_____
Signature

M.D. # ___ ___ ___ ___ ___

Must call Blood Bank to initiate release

BLOOD BANK USE ONLY

LOC _____ Ordered by: _____
READ BACK & CONFIRMED BY: _____
Date: _____ Time: _____

BLOOD BANK USE ONLY

☐ COMP. HX CHECK: ABO/Rh
☐ Need Check Specimen
☐ ABO Confirmation Completed

SPECIAL REQUIREMENTS CHECK:
☐ No Special Req. on file ☐ Washed
☐ Irradiation ☐ Vol Red
☐ CMV Negative ☐ Hgb S Neg.
☐ Other: _____

☐ BMT ABO Requirements

RBC _____ FFP _____ PLT _____

COMMENTS
☐ Antibodies: _____

Most recent labs as of _____

PLATELET COUNT _____ $X10^9$/mL

PT _____ INR _____ Fib _____

DATE/TIME: _____ INITIAL: _____

NOTIFICATION BY: _____

PERSON NOTIFIED: _____

Date: _____ **Time:** _____

☐ BLOOD READY Loc / Ext. _____
☐ NEEDS / SPECIMEN
☐ OTHER: _____

TEST	Patient age	Preferred Volume (EDTA = purple top)*	Minimum Volume (EDTA= purple top)*
Type and Screen &/or Crossmatch			
	Infant < 4 mo	Full microtainer**	Full microtainer**
	Peds 4 mo – 1 yr	3 mL	1 mL
	Peds 1 - 18 yrs	3-6 mL (3 mL tube OK for small children)	3 mL
	> 18 yrs	6 mL	5 mL
Check specimen			
	Infant < 4 mo	Full microtainer**	Full microtainer**
	Any patient > 4 mo	3 mL	1 mL

* Additional sample may be required for antibody identification or further testing
** A full microtainer = 0.8 mL
All specimen tubes must be signed and dated