Oregon Health & Science University
Portland, OR 97239
Hospitals and Clinics

DOWNTIME INPATIENT/ED
BLOOD PRODUCT AND
TRANSFUSION ORDER

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Deliver specimen to HRC 9D20, Pneumatic Tube Station: 950 or 13, Phone: 4-8537

Note: All specimens for pretransfusion testing must be labeled at the patient's bedside with patient's full name, MR#, date collected, and full signature of phlebotomist. Prior to transfusion, consent for transfusion must be documented in the patient's chart. See on-line blood consent form: http://ozone.ohsu.edu/healthsystem/HIS/co1407.pdf

PLEASE COMPLETE THE FOLLOWING:
I verify that the sample submitted is correctly labeled with the name/medical record number of the patient whose blood was drawn.

Location: _____ Phone: _____ Ordering Physician: _____

Date and time needed: _____ Diagnosis/Indication: _____

Is this a Hem/Onc, solid organ, or BMT candidate/recipient? _____ Yes _____ No

Special Product Needs (e.g. Leukoreduced/CMV-safe, Irradiated, HBS neg, RC5, etc., list all that apply):

Blood Product/Transfusion Service Work Requested:

____ Type and Screen ____ ABORh ____Direct Anti-Globulin Test

____ Red Cells: _____ unit(s) of _____

____ Other Products (platelet pheresis, FFP, cryo, etc.) _____ unit(s) of _____

____ Aliquots (peds/neo): Volume _____ Product _____

____ Cord Blood Routine ____ RhoGam Workup (____ Weeks Gestation)

____ Hold Sample, Do Not Process ____ Other (specify) _____

TRANSFUSION SERVICE USE ONLY:

RECEIVED TIME:

ABO/RH TYPE & RETYPE REVIEW OF HISTORY:

SAMPLE NUMBER:

	anti-A	anti-B	Anti-D	D Cont	A1 cell	B cell	ABO/Rh	Tech	Date
Initial Type									
Retype									

ANTIBODY SCREEN

1 AHG	2 AHG		INTERP	TECH	DATE

OTHER TESTS/COMMENTS:

Revised 03-25-2015