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 online 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) __________________________

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<tr>
<th>ABO/RH TYPE &amp; RETYPE</th>
<th>REVIEW OF HISTORY</th>
<th>SAMPLE NUMBER</th>
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<td>Anti-D</td>
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ANTIBODY SCREEN

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Revised 03-25-2015