

BLOOD BANK

CHART COPY

RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER
 1653 WEST CONGRESS PARKWAY • 262 JELKE, CHICAGO, ILLINOIS 60612-3833 • 312.942.5920



TRANSFUSION REQUISITION #5709

FOR BLOOD BANK USE ONLY

DATE/TIME RECEIVED _____

SAMPLE# _____ SAMPLE REQUESTED DATE/TIME _____

REQUESTED FROM _____

TECH _____

CURRENT / PRIOR RECORDS (✓) _____ PTC FHR

AUTO/DIRECTED

TECH _____

ADDRESSOGRAPH

- ROUTINE (◇ INDICATE DATE & TIME OF TRANSFUSION BELOW)
- TOMORROW SURGERY
- STAT

FORWARD THIS REQUISITION TO THE BLOOD CENTER.
 ORDER TYPE & SCREEN IN POE OR ON REQ. #4009.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

DIAGNOSIS _____

PREVIOUS TRANSFUSIONS (Y/N) _____ DATE OF LAST _____ NUMBER OF PREGNANCIES _____ DATE OF LAST _____

SPECIAL REQUIREMENTS:

- AUTOLOGOUS*
- DIRECTED DONOR*
- LEUKOREduced
- IRRADIATED
- CMV RISK REDUCED
- HLA MATCHED *
- HYPER-CONCENTRATE TO _____ ML
- EXCHANGE TRANSFUSION _____
- OTHER _____

* PRODUCTS AVAILABLE: (SEE BACK FOR PRODUCT INFORMATION)
 * PRIOR ARRANGEMENT MUST BE MADE WITH BLOOD CENTER;

INDICATE TOTAL NUMBER OF EACH PRODUCT BEING REQUESTED. IT IS IMPORTANT TO INDICATE DATE AND TIME OF TRANSFUSION.

| #. | DATE NEEDED | TIME | #. | DATE NEEDED | TIME | #. | DATE NEEDED | TIME |
|-------------------------------------|-------------|-------|--|-------------|-------|----------------------------------|-------------|-------|
| + | _____ | _____ | + | _____ | _____ | + | _____ | _____ |
| UNITS AUTOLOGOUS BLOOD | | | PEDIATRIC PLATELETS (40-60ML from 1 donor) | | | OTHER | | |
| + | _____ | _____ | + | _____ | _____ | vials Rh IMMUNOGLOBULIN | | |
| UNITS PACKED RED BLOOD CELLS | | | POOLED PLATELETS (1 Pool = 4 donors) | | | mcg WinRho | | |
| + | _____ | _____ | + | _____ | _____ | COAG FACTORS (SEE BACK FOR LIST) | | |
| mls RBC (PEDIATRIC UNIT) | | | PLATELETS BY APHERESIS (Single donor approx. 250 ML) | | | Product Name | | |
| + | _____ | _____ | + | _____ | _____ | IU/mcg | | |
| UNITS FRESH FROZEN PLASMA | | | POOLED CRYOPRECIPITATE (1 Pool = 4 donors) | | | | | |
| + | _____ | _____ | | | | | | |
| CUSTOMIZED WHOLE BLOOD FOR EXCHANGE | | | | | | | | |

LR = LEUKOREduced

TRANSFUSION INDICATIONS: (SEE BACK FOR INFORMATION)

- PLTS LESS THAN 50,000 WITH BLEEDING
- ACUTE BLOOD LOSS AND/OR SHOCK
- FACTOR VIII LESS THAN 10%
- INTRAOPERATIVE
- PLTS LESS THAN 20,000
- PRE-OPERATIVE
- INR GREATER THAN 1.5
- PLASMA EXCHANGE
- PLT DYSFUNCTION
- HGB LESS THAN 10
- PTT GREATER THAN 50 SEC.
- OTHER _____

PHYSICIAN'S SIGNATURE _____

PAGER NO. _____

EMERGENCY

EMERGENCY CIRCUMSTANCES REQUIRE IMMEDIATE TRANSFUSION OF UNCROSSMATCHED RED CELLS. CALL BLOOD BANK OR SEND REQUISITION WITH COURIER WHO WILL PICK UP BLOOD.

ONLY

- ABO AND RH TYPE SPECIFIC RED CELLS WITHOUT CROSSMATCH UNIT#: _____
- MAXIMUM OF 2 UNITS GROUP O, Rh NEG RED CELLS WITHOUT CROSSMATCH (ADDITIONAL UNITS PROVIDED WITHOUT TYPING WILL BE GROUP O, Rh POS)

SPECIAL CIRCUMSTANCES REQUIRE TRANSFUSION WITH INCOMPLETE OR NONSTANDARD TEST RESULTS.

- LEAST INCOMPATIBLE
- WITHOUT COMPLETION OF EXTENDED ANTIBODY WORKUP
- UNIT WITH INCOMPLETE INFECTIOUS DISEASE TESTING
- UNIT WITH POSITIVE INFECTIOUS DISEASE TEST AS INDICATED _____

EMERGENCY CLINICAL CIRCUMSTANCES

AUTHORIZING PHYSICIAN _____

M.D. BLOOD BANK USE ONLY
 ISSUED TO: _____