

Request for Blood Components - Named Patient

Parent document: SOP-00070

[AHP code]	[AHP name]	Phone	[phone number]
		Fax	[fax number]
		Email	[email]

Fax completed order to Lifeblood	(08) 8422 1302	Local Customer Service phone number	(08) 8223 6090
----------------------------------	----------------	-------------------------------------	----------------

Local Customer Service email	[email]
------------------------------	---------

Order prioritisation	<input type="checkbox"/> Routine	<input type="checkbox"/> Urgent	<input type="checkbox"/> Life threatening
----------------------	----------------------------------	---------------------------------	---

Date/Time required	
--------------------	--

Ordered by	[name]	Date	[date]
------------	--------	------	--------

Patient information (Complete all fields)

Patient details or affix hospital label		Patient diagnosis and relevant information	
Surname		ABO/Rh	
First name		Known phenotype	
UR number		Known antibodies	
Date of birth		Red cell requests: please provide Hb level	g/l
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Weight	Platelet requests: please provide platelet count	x10 ⁹ /L
Ward		Reason for request:	
Requesting doctor/ consultant	[name] [phone/pager]		

Fresh component request information

<input type="checkbox"/> CMV Negative	<input type="checkbox"/> Phenotyped	Negative for phenotype			
Red cells	Qty	Platelets	Qty	Frozen components	Qty
<input type="checkbox"/> Irradiated		Apheresis		Clinical fresh frozen plasma (cFFP)	
Red cells		Pooled		Cryoprecipitate	
Paediatric (1=1 small unit)		Either		<input type="checkbox"/> WB derived <input type="checkbox"/> Apheresis	
Washed		Paediatric platelets		Cryo-depleted plasma (CD-plasma)	
For IUT		HLA Compatible			
Other		Additional comments			

Lifeblood Use Only

NBMS order number		Taken by	
Delivery details			