

# Request for Blood Components - Named Patient

Parent document: SOP-00070

<b>[AHP code]</b>	<b>[AHP name]</b>	Phone	[phone number]
		Fax	[fax number]
		Email	[email]

Fax completed order to Lifeblood	(08) 9421 2847 or (08) 9221 1215	Local Customer Service phone number	(08) 9421 2374 or (08) 9421 2800
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Local Customer Service email	[email]
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Order prioritisation	<input type="checkbox"/> Routine	<input type="checkbox"/> Urgent	<input type="checkbox"/> Life threatening
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Date/Time required	
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Ordered by	[name]	Date	[date]
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**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 <sup>9</sup> /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			