

HOSPITAL

HOSPITAL NO.

PUGET SOUND BLOOD CENTER

PREADMISSION REQUEST FOR BLOOD

PATIENT NAME

FIRST

MIDDLE

PHYSICIAN REQUESTING BLOOD

SOCIAL SECURITY NO.

BIRTHDATE

DIAGNOSIS/PROCEDURE

BLOOD CENTER USE ONLY

TIME IN

 PREADMISSION TYPE AND SCREEN
 PREADMISSION CROSSMATCH

PLANNED SURGERY

DATE

TIME

 Have you been pregnant in the last 3 months? No Yes

 Have you received a transfusion in the last 3 months? No Yes

 X _____
PATIENT (GUARDIAN) SIGNATURE

 X _____
PERSON COMPLETING REQUEST

 X _____
PERSON DRAWING BLOOD

 DATE
DRAWN _____

FORM 320-17 (REV 1/01)

NO. OF UNITS

RED BLOOD CELLS

 LEUKOCYTES REDUCED

 IRRADIATED

 CMV NEG*

OTHER (SPECIFY) _____

 * LEUKOCYTES REDUCED WILL BE
SUBSTITUTED IF CMV NEG IS NOT AVAILABLE.

Patient History	ABO/Rh	Antibody (ies)	AHG XM required?	Triage Tech
			No Yes	
Automated Testing	1st ABO/Rh	2nd ABO/Rh	.SC1	
			Neg Pos	
Computer X-Match Checks	1st ABO/Rh	2nd ABO/Rh	C-XM OK?	C-XM Tech
	Done	Done	Yes No	

 TRANSFUSED IN
LAST 3 MONTHS? NO YES

TECH _____

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