

INFANT PROTOCOL REQUEST FOR BLOOD

SEND COMPONENTS TO:	HOSPITAL NO.	
PATIENT LAST NAME	FIRST	MIDDLE
SOCIAL SECURITY NO.	BIRTHDATE	
ORDERING FACILITY (IF DIFFERENT THAN ABOVE):		

**PUGET SOUND BLOOD CENTER**  
 921 TERRY AVE. SEATTLE, WA 98104-1256  
**INFANT PROTOCOL REQUEST FOR BLOOD**

PHYSICIAN REQUESTING BLOOD	PIN
DIAGNOSIS / PROCEDURE	
SERVICE OR UNIT & TELEPHONE NUMBER	

BLOOD CENTER USE ONLY		
		TIME IN

<input type="checkbox"/> <b>INITIAL TYPE &amp; SCREEN</b>	
<input type="checkbox"/> <b>INITIAL DIRECT ANTIGLOBULIN TEST</b>	
<input type="checkbox"/> <b>EMERGENCY</b>	
<input type="checkbox"/> <b>Emergency Uncrossmatched</b> <small>(Physician justification required; Pretransfusion testing in progress)</small>	
<input type="checkbox"/> <b>Emergency Crossmatched</b> <small>(Release as soon as pretransfusion testing is completed)</small>	
<input type="checkbox"/> <b>ROUTINE</b>	
<input type="checkbox"/> WITHIN 4 HOURS	
<input type="checkbox"/> <b>PLANNED TRANSFUSION</b>	DATE/TIME REQUIRED
<input type="checkbox"/> <b>SURGERY</b>	DATE/TIME REQUIRED

**Indicate Number of Units:**

<input type="checkbox"/> <b>PEDIATRIC/DIVIDED RBC</b> Leukocytes Reduced HgbS Neg (4 pacs)	<input type="checkbox"/> IRRADIATED
<input type="checkbox"/> <b>ASSIGNED</b> Leukocytes Reduced HgbS Neg (8 pacs)	<input type="checkbox"/> IRRADIATED
<input type="checkbox"/> <b>RED BLOOD CELLS</b>	<input type="checkbox"/> LEUKOCYTES REDUCED
	<input type="checkbox"/> IRRADIATED
	<input type="checkbox"/> CMV NEG*
<input type="checkbox"/> <b>DIRECTED</b>	<input type="checkbox"/> Pediatric/Divided RBC
	<input type="checkbox"/> Assigned/Divided RBC
	<input type="checkbox"/> Red Blood Cells

**Mother:**

Name: \_\_\_\_\_

Hospital No: \_\_\_\_\_

**Sample:**     Cord Blood  
                    Peripheral Blood

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

<b>X</b>	_____
	Person Completing Request
<b>X</b>	_____
	Person Collecting Blood Sample
	_____
	Date/Time Drawn