NewYork-Presbyterian

Transfusion Medicine / Blood Bank

ROUTINE / STAT BLOOD PRODUCT ORDER FORM

IF NO PATIENT LABEL: PRINT NAME, SEX AND MRN ON FORM

Date: ______________________ **Time:** ______________________

Expected Transfusion Date: ______________ **Location:** ______________ **Call Back Number:** ______________

Patient Name:____________________________ **DOB:** ____________ **MRN:**_________________________

Sex: M / F (circle one) **Patient's Weight:** _________**kg** (Pediatrics < 25 kg, order in mL)

Priority:

☐ **Routine Blood Products** (available ≤ 4 hours, crossmatched units) ☐ **STAT Blood Products** (available ≤ 2 hours, crossmatched units)

Red Blood Cells	**Plasma**	**Platelets**	**Cryoprecipitate**
# _________ Units/ mL (Circle one)	# _________ Units/ mL (Circle one)	# _________ Products/ mL (Circle one)	# _________ Products/ mL (Circle one)

☐ RhIG – IM ______________ Vial(s) ☐ RhIG – IV ______________ International Units *(patient's weight required)*

Special Instructions:

☐ Patient has transfusion-dependent thalassemia or sickle cell disease ☐ Irradiation ☐ Other: ______________

MD/NP/PA Print: ______________________________________ **Signature:** ______________________________________

MD Code or CWID: ____________________________________