NewYork-Presbyterian

Attach Patient Label Here

Transfusion Medicine

Blood Bank

EMERGENCY RELEASE
Order Form & Pick-up Slip
Prepare Emergency Release

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

Patient Information

Patient Name:_____ **MRN:**_____ **DOB:**_____

Patient Location: _____ **Sex: M / F** (circle one) **Date / Time** _____/_____

Order Information

Ordering / Supervising MD / DO Print Name or CWID: _____ **Signature:** _____

Ordering NP / PA Print Name or CWID: _____ **Signature:** _____

Note: Per regulations, NP / PA orders require supervising physician (MD/DO) co-sign this form at the time of order. If no in-house physician is present, the Supervising physician's 'Name' is required at the time of order, and this form must then be signed by the Supervising physician within 24 hours.

I acknowledge the increased risk of using blood before all pre-transfusion testing is completed, including crossmatch, and would like to proceed with this transfusion: YES NO (circle one)

I have contacted the Blood Bank by phone for this Emergency Release Protocol order: YES NO (circle one)

Blood Product (s) Requested:

Number of RBC Units (1 – 4): _____ **Number of Platelets Units (1):** _____ **Number of Plasma Units (1 – 4):** _____

Transport Options: Pneumatic Tube / In Person (circle one) **Tube Station Number (where applicable):** _____

Dispense Information

Issued by: _____ **I acknowledge patient verification as I issue this product Date / Time** _____/_____

Issued to: _____ **I acknowledge patient verification as I receive this product Date / Time** _____/_____

Blood Bank Use Only

Donor # _____ **ABORh** _____ **Donor #** _____ **ABORh** _____

Donor # _____ **ABORh** _____ **Donor #** _____ **ABORh** _____

Specimen Received	No	Yes	N / A	Date / Time	When was it tested?
ABO Confirmation					☐ Pre-issue ☐ Post-issue ☐ N/A
Type and Screen					☐ Pre-issue ☐ Post-issue ☐ N/A

Transfusion Medicine MD notified of positive antibody history, antibody screen and / or incompatible crossmatches (if applicable)

Review Patient History	☐ Yes ☐ Pos Antibody hx – MD Notified Immediately	Notification Date/Time:
Antibody Screen:	☐ Negative ☐ Positive - MD Notified Immediately	Notification Date/Time:
Incompatible Crossmatch	☐ No ☐ Yes - MD Notified Immediately	Notification Date/Time:

Unit Information: See LIS for details.

Crossmatch Completed by: _____ Crossmatch Completed Date & Time: _____

Supervisor Review: _____ Date / Time: _____