ST. VINCENT CHARITY
MEDICAL CENTER
2351 EAST 22ND STREET
CLEVELAND, OH 44115
stvincentcharity.com
A Ministry of the Sisters of Charity Health System

BLOOD BANK
REQUEST FOR SERVICE

Location ______________________________

Patient Name: ______________________________

Service Date ______________________________

____
Last First Name Middle

Ordering Physician ______________________________

Medical Record # ______________________________

_____ Medical

Account # ______________________________

Indication for transfusion

____

SS # (if indicated) ______________________________

Birthday/Age ______________________ Sex ____________

_____ Surgical

Attending Physician ______________________________

Surgery Date ______________________________

BBREQ — Blood Bank Request for Service

Services Requested (see code in back)

____

☐ Routine ☐ Stat ☐ Urgent

Blood Bank Request for

☐ FFP (BBREQF)

BBREQR — Blood Bank Request For Red Cells

☐ PLATELETS (BBREQP)

_____ Type, Screen and Crossmatch

☐ CRYO (BBREQC)

Number of Units ____________

Number of units ____________

To be transfused on ______________________________

To be transfused on ______________________________

Hold ______________________

Hold ______________________

RECIPIENT'S IDENTIFICATION VERIFIED

SPECIMEN DRAWN BY ______________________________ DATE ____________ TYPENEX ID ____________
Signature

PREVIOUS TRANSFUSION: ☐ YES ☐ NO IF YES, DATE LAST TRANSFUSED: ______________________

SVPOD-174 (6/01)

BLOOD BANK REQUEST FOR SERVICE:

*ABORH_______ ABO/RH TYPE ONLY

*TS ___________ TYPE AND SCREEN

*ABSC ________ ANTIBODY SCREEN (INDIRECT COOMBS)

*DATABS ______ DIRECT AND INDIRECT COOMBS

*DATP ________ DIRECT ANTIGLOBULIN TEST

*RHIG ________ RHOGAM SCREEN

*TP ___________ THERAPEUTIC PHLEBOTOMY

*TRXN ________TRANSFUSION REACTION

CRITERIA FOR SAMPLE COLLECTION:

*DRAW ONE 7ml EDTA (PURPLE) TOP

*SILICON TUBE NOT ACCEPTABLE

*SAMPLES MUST BE LABELED WITH:

1. PATIENT'S FULL NAME.
2. IDENTIFICATION NUMBER.
3. DATE OF SAMPLE COLLECTION.

*SAMPLES NOT ACCEPTABLE IF:

1. UNLABELED OR PARTIALLY LABELED.
2. HEMOLYZED

TRANSFUSION REQUEST MUST INCLUDE:

*TYPENEX ID ON ALL TYPE & CROSSMATCH

& TYPE & SCREEN (POTENTIAL XMATCH)

1. PATIENT'S FULL NAME.
2. UNIQUE IDENTIFICAITON NUMBER.
3. SS# IF UNIQUE ID NUMBER NOT AVAILABLE.
4. AGE, SEX, AND DATE OF BIRTH.
5. SIGNATURE OF PERSON WHO IDENTIFIED RECIPIENT,

   DREW AND LABELED BLOOD SAMPLE.
6. DATE OF SAMPLE COLLECTION.