

SPECIAL REQUEST ORDER FORM

All Orders must be faxed

DO NOT USE THIS FORM FOR HLA/HPA SELECTED for IUTs - USE FORM 1000101869 Request for HLA/HPA

Selected Platelets



SECTION 1: TO BE COMPLETED BY HOSPITAL

Routine (next run) ☐ ASAP (prior to next scheduled run) ☐ **STAT Must be faxed and phone** ☐

Transfusion or Surgery Date: YYYY-MM-DD Delivery Mode: _____

Comments: _____

Hospital: _____ City/Town: _____

Requested by: _____ Date and Time: YYYY-MM-DD HH:MM Phone/Fax: _____

Patient Information or **Patient Unique Identifier** (i.e. last name plus last 4 digits of PHN): _____
☐ **N/A- for Stock** **Patient's Antibodies Identified:** _____

Required Negative Antigen(s) Please Choose all that apply below and add any missing in Other

C E c e K Fy^a Fy^b Jk^a Jk^b S s Other: _____

ABO Compatible Substitution Acceptable? Yes ☐ No ☐ **If no Why?** (record reason in Comments below)

Comments: _____

RBC Units Required: Amount (# or mL) & ABO/Rh: _____

Additional requirements (check all that apply)
☐ Irradiated ☐ Washed ☐ Recipient with anti IgA Antibodies ☐ as fresh as possible
☐ For Stock Only ☐ Other – Specify: _____
☐ IUT RBC (CMV Negative) ☐ IUT PLATELET Non-HLA/HPA (CMV Negative)
 Check irradiated box above if required Check irradiated box above if required
Amount (# or mL) & ABO/Rh: _____

Comments: _____

Rare Blood Program: Inquiry Only ☐ **SECTION 2: FOR CBS USE ONLY** **Donor Testing demand request** ☐

Rare Blood Medical Consultation, if required: _____

Donation Numbers of Acceptable Units (if applicable)

To be filled: Check if Rare ☐ **Amount (# or mL) & ABO/Rh:** _____ **PROGESA Order #:** _____

CBS Comments: _____

Site _____ Fax Number _____ Phone Number _____

Confidential

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