Request for Blood Components

THE BLOOD CENTER – REFERENCE LABORATORY

☐ **NEW ORLEANS LAB**

Phone # 504-592-1569

Fax # 504-592-1570

*****FOR BLOOD SAMPLE PICKUP CALL*****

Hospital Services – 1-985-340-2343 or 1-985-345-9817

☐ **HAMMOND LAB**

Phone # 985-345-4092

Fax # 985-902-7918

SPECIMEN REQUIREMENTS – 2 FULL PLAIN RED TOPS & 2 FULL PURPLE/PINK TOPS

NOTE: All tubes *MUST* be labeled with the patient's full name (including middle initial/name), SSN or MR#, collection date/time and phlebotomist initials. Blood bank armband stickers *MUST* be on all specimens.

*****MISLABELED SPECIMENS CANNOT BE RELABELED AND *WILL BE REJECTED AND DISCARDED.******

Requesting Facility: (Facility Name & Phone #)

Affix patient sticker here

Patient: Last Name | First Name | Middle initial/name | Sex | Date of Birth

☐ **M** ☐ **F** / /

Test requested (check one box only):

☐ **TYPE AND SCREEN ONLY– NO BLOOD CROSSMATCHED**

☐ **CROSSMATCH UNITS**

☐ **EMERGENCY RELEASED UNITS**

****NOTIFY LAB PERSONNEL BY PHONE****

Indicate number of units requested:

_____**RED BLOOD CELLS** _____**PLATELETS**

_____**FRESH FROZEN PLASMA**

Check if special needs requested:

_____ **Leukoreduced** _____ **Autologous**
_____ **CMV Negative** _____ **Directed/Designated**
_____ **Sickle Cell Negative** _____ **Irradiated**

Priority of testing (check one box only):

☐ **STAT – Testing/transfusion is needed immediately**

☐ **ASAP – Testing/transfusion is needed within 8 hours**

☐ **ROUTINE**

☐ **HOLD UNITS AT THE BLOOD CENTER UNTIL CALLED**

FOR SCHEDULED PROCEDURES ONLY:

DATE AND TIME NEEDED _____

SAMPLE VALID FOR **14 DAYS ONLY IF NO TO BOTH OF THE FOLLOWING (*BOTH MUST BE CIRCLED*):**

BLOOD PRODUCTS TRANSFUSED IN LAST 3 MONTHS? **YES** **NO**

PREGNANCY IN LAST 3 MONTHS? **YES** **NO**

NOTE: IF EITHER OF THE ABOVE IS "YES", SAMPLE IS **VALID FOR 3 DAYS *ONLY***

Medical Record Number

Social Security Number

Blood bank armband number

Indicate number of filters (if needed):

_____ **Standard filter (Infusion set)**

_____ **Leukoreduction filter**

Sample collected:

Date_____**Time**_____

Phlebotomist_____

Additional Comments

White copy – Send with Specimen Yellow Copy – Retain for your records

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