THE BLOOD CENTER
Serving you for life!

BLOOD PRODUCT FAX ORDER FORM

DATE/TIME:_____

Client:_____ **Person placing order:**_____

Client Phone#: __ __ __ - __ __ __ - __ __ __ __ **Client Fax#:** __ __ __ - __ __ __ - __ __ __ __

Priority (check one): ___ Stock ___ASAP* ___STAT* (*additional charges may apply)

(Please indicate number of units required in spaces below)

Component	O pos	A pos	B pos	AB pos	O neg	A neg	B neg	AB neg
Red Blood Cells								
Platelets								
Platelet Pheresis								
Cryoprecipitate								
Fresh Frozen Plasma								
Other (please specify)								

Additional Requirements	Yes	No	Indicate which products and how many if multiple products have been requested.
Leuko-Reduced			
Irradiated			
CMV Negative			
Sickle-Cell Negative			
Volume Reduced			Indicate volume required:____cc
Pooled			
Other (please specify)			

Acceptable alternative if products requested are unavailable:_____

FAX ORDER TO: 985-340-2344

For ASAP and STAT Orders: call Hospital Services at 985-345-9817 before faxing

TBC staff member notified of fax:_____ Date:_____ Time:_____

**********For TBC Use Only**********

Order received by:_____ Date:_____ Time:_____

Component	O pos	A pos	B pos	AB pos	O neg	A neg	B neg	AB neg
Red Blood Cells								
Platelets								
Platelet Pheresis								
Cryoprecipitate								
Fresh Frozen Plasma								
Other (please specify)								

Order confirmation fax sent by:_____ Date:_____ Time:_____

Order confirmation fax sent by:_____ Date:_____ Time:_____

Order Completed ☐

_____
Initials/ Date