

# PREADMISSION REQUEST FOR BLOOD



HOSPITAL		HOSPITAL NO			
PATIENT LAST NAME		FIRST	MIDDLE	PHYSICIAN REQUESTING BLOOD	
SOCIAL SECURITY NO.		BIRTHDATE		DIAGNOSIS/PROCEDURE	
PLANNED SURGERY		FOR HAEMOBANK CUSTOMERS:		BLOODWORKS USE ONLY	
DATE	TIME	<input type="checkbox"/> IF NOT ELECTRONIC CROSSMATCH (RA) ELIGIBLE, SEND: RED BLOOD CELLS-LEUKOCYTE REDUCED <input type="checkbox"/> IRRADIATED		Tech ID	Timestamp
<input type="checkbox"/> <b>PREADMISSION TYPE &amp; SCREEN</b>		# OF UNITS NEEDED: <input style="width: 50px; height: 30px;" type="text"/>		HX <input type="checkbox"/> Tech ID: _____ Date: _____ ABO/RhD: _____ HX of Ab: _____ Last Panel Date: _____	
<input type="checkbox"/> <b>PREADMISSION CROSSMATCH</b>				<b>HISTORICAL BLOOD TYPE VERIFIED WITH BLOODWORKS?</b> If no historical blood type, send additional separately drawn specimen with BW confirmatory ABO/RH request.	
Have you been pregnant in the last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Historical blood type confirmed		<b>TRANSFUSED IN LAST 3 MONTHS?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES	
Have you received a transfusion in the last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Confirmatory ABO/Rh to be collected		TECH ID _____ DATE _____	
<input checked="" type="checkbox"/> PATIENT (GUARDIAN) SIGNATURE		<b>(2) 7 mL EDTA Specimens Required</b>		Comments: _____	
<input checked="" type="checkbox"/> PERSON COMPLETING REQUEST					
<input checked="" type="checkbox"/> PERSON DRAWING BLOOD					
<input checked="" type="checkbox"/> 2ND PERSON REVIEWING PATIENT ID <small>(if required by hospital policy)</small>					
DATE DRAWN	TIME DRAWN				

CENTRAL TSL 206-689-6525 | EVERGREEN TSL 425-434-4949 | OVERLAKE TSL 425-689-5084 | SKL TSL 425-656-7900

TO REORDER FORM-00285 06 VISIT <https://tinyurl.com/bloodworks-forms-request>

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