

Ph: (206) 689-6525
 Ph: (425) 688-5084
 Ph: (425) 656-7900
 Ph: (425) 434-4949
 Ph: (206) 987-5151

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PREADMISSION REQUEST FOR BLOOD

HOSPITAL		HOSPITAL NO.		BLOODWORKS PREADMISSION REQUEST FOR BLOOD																			
PATIENT LAST NAME		FIRST	MIDDLE					PHYSICIAN REQUESTING BLOOD															
SOCIAL SECURITY NO.		BIRTHDATE		DIAGNOSIS/PROCEDURE																			
<input type="checkbox"/> PREADMISSION TYPE AND SCREEN		FOR HEMOSAFE CUSTOMERS: <input type="checkbox"/> IF NOT ELECTRONIC CROSSMATCH(RA) ELIGIBLE, SEND:		BLOODWORKS USE ONLY																			
<input type="checkbox"/> PREADMISSION CROSSMATCH		# OF UNITS <input style="width: 40px; height: 20px; border: 1px solid blue;" type="text"/> RED BLOOD CELLS-LEUKOCYTE REDUCED <input type="checkbox"/> IRRADIATED		Tech ID		Timestamp																	
<table border="1" style="width: 100%;"> <tr> <th colspan="2">PLANNED SURGERY</th> </tr> <tr> <th>DATE</th> <th>TIME</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>		PLANNED SURGERY		DATE	TIME			<p style="text-align: center;">HISTORICAL BLOOD TYPE VERIFIED WITH BW?</p> <p>If no historical blood type, send additional separately drawn specimen with BW confirmatory ABO/RH request.</p> <input type="checkbox"/> Historical blood type confirmed <input type="checkbox"/> Confirmatory ABO/Rh to be collected		Patient History		ABO/Rh	Antibody (ies)	AHG XM required?	Triage Tech								
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(2) 7 mL EDTA Specimens Required
 19-9-169 04

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