## PREADMISSION REQUEST FOR BLOOD

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

 $\textbf{CENTRAL TSL} \ 206-689-6525 \ \ | \ \ \textbf{EVERGREEN TSL} \ 425-434-4949 \ \ | \ \ \ \textbf{OVERLAKE TSL} \ 425-689-5084 \ \ | \ \ \ \textbf{SKL TSL} \ 425-656-7900$ 

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FREADINIOSION REC	KOLSI I ON BL	<b>⊘</b> Bloodworks Labs		
HOSPITAL		HOSPITAL NO.	LABORATORY SERVICES	
PATIENT LAST NAME FIRST		MIDDLE	PHYSICIAN REQUESTING BLOOD	
SOCIAL SECURITY NO.		BIRTHDATE	DIAGNOSIS/PROCEDURE	
PLANNED SURGERY		FOR HAEMOBANK CUSTOMERS:	BLOODWORKS USE ONLY	
DATE	TIME	☐ IF NOT ELECTRONIC CROSSMATCH (RA) ELIGIBLE, SEND:	Tech ID Tir	mestamp
PREADMISSION TYPE & SCREEN		RED BLOOD CELLS-LEUKOCYTE REDUCED ☐ IRRADIATED	нх 🗆	
PREADMISSION CROSSMATCH		# OF UNITS NEEDED:	Tech ID: Date: ABO/RhD:	
Have you been pregnant in the last 3 months?  □ No □ Yes				
Have you received a transfusion in the last 3 months?  □ No □ Yes		HISTORICAL BLOOD TYPE VERIFIED WITH BLOODWORKS? If no historical blood type, send additional	Specimen #	
X PATIENT (GUARDIAN) SIGNATURE		separately drawn specimen with BW confirmatory ABO/RH request.	TRANSFUSED IN LAST 3 MONTHS?	
X PERSON COMPLETING REQUEST		Historical blood type confirmed	□ NO □ YES	
X PERSON DRAWING BLOOD X 2ND PERSON REVIEWING PATIENT ID		Confirmatory ABO/Rh to be collected	TECH IDDATE	
(if required by hospital policy)  DATE DRAWN	TIME DRAWN	(2) 7 mL EDTA Specimens Required	Comments.	

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