BLOOD PRODUCT ORDER FORM

Beginning of Form

Order #:	
Hospital:	Date:
Ordered By:	Time:
Received By:	Repeated By:

Requested Delivery	
STAT	ASAP
AM	PM
Date/Time:	

Leukoreduced RBCs			
Type	# Ordered	Special Tests	Filled
O+			
A+			
B+			
AB+			
O=			
A=			
B=			
AB=			

Platelets	
Inventory Dates:	Return Dates:
Ordered:	Filled:
Special Requests	CMV negative Irradiated

Frozen Products				
Type				
	Need	Filled	Need	Filled
O				
A				
B				
AB				

Antigen Screenings		
Patient Name:		Patient ABO/Rh:
Antigen(s) to be screened:	# Units	Ordered ABO/Rh:
Ordering Physician:	Circle all that apply: Irradiated CMV Neg	

Special Orders:	Filled

MVRBC Use Only			
STAT ONLY			
Fax Received		Order Written on Log:	
Time Sent		Order Filled By:	

Comments/Variations:

End of Form