Gulf Coast Regional Blood Center

Address: 1400 La Concha Houston TX 77054 **Ph**: 713-791-6286
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GCRBC use only; Case #

Blood Component Request

	Order Date:	**Add-on Request:** ordered by (initials)/date/time
	FACILITY:	
	RN Phone:	
	Facility Fax:	
	Patient Location:	
☐ Male ☐ Female	Ordering Physician:	
Affix PATIENT registration label with full name and DOB here. *Information must match specimen label.*	Admitting Diagnosis:	

Component	# of Units	Laboratory Results	SPECIAL NEEDS
☐ RBCs		Hgb (g/dL): Hct (%):	☐ **Irradiated**
☐ Platelets		Plt count (/uL):	☐ **Sickle Cell Negative**
☐ Plasma		PT (sec): INR: PTT (sec):	☐ **CMV Negative**
☐ Cryoprecipitate		Fibrinogen (mg/dL):	
☐ Type &Screen only ☐ Direct Antiglobulin (Coombs) Test (DAT)			☐ **Auto/Designated Donors**

Delivery Date **Time**		**HOLD**	Special Delivery Instructions
	a.m.		
	p.m.	☐	

For Extended Crossmatch Only:
The patient/legal representative affirms that he/she has **not** been transfused or pregnant within the past three months.

Signature of nurse verifying history (first and last name)

Specimen Requirements		
	Purple-top/EDTA tube(s) (one 9-10 mL or two 5-7 mL tubes). Label tube(s) with: Patient's Full Name Date of Birth (DOB) (mm/dd/yy) Initials of Phlebotomist Date/Time of Collection *Incorrect, illegible, incomplete or discrepant samples and/or forms will be rejected.*	***I certify that the patient's name and DOB are identical on the patient's wristband, the specimen label, and the request form.*** Signature of Phlebotomist Date (mm/dd/yy) & Time of Specimen Collection 2nd Signature Verifying Patient Data

Blood Center Use Only: ST-Tx Patient ID : _____ ST-TX Order : _____