

REQUEST FOR GRANULOCYTE PRODUCTS

Hospital Name	Hospital Code
Ordering Physician	Physician Phone
Contact Person	Contact Phone

Patient Information

(please print)

Patient Name _____
(last name, first name)

Patient ID Number _____ Date of Birth _____
(MM/DD/YYYY)

Primary Diagnosis _____

Transplant Performed:

- No
- Yes Date of transplant _____ Transplant Donor ABO/Rh _____
- | | |
|--|--|
| <input type="checkbox"/> Autologous Bone Marrow | <input type="checkbox"/> Allogeneic Bone Marrow |
| <input type="checkbox"/> Autologous Peripheral Blood Stem Cell | <input type="checkbox"/> Allogeneic Peripheral Blood Stem Cell |
| <input type="checkbox"/> Umbilical Cord Blood | <input type="checkbox"/> Other _____
<small style="margin-left: 150px;">(specify)</small> |

Documented Infection:

- No
- Yes (specify below)
- | | |
|---|--|
| <input type="checkbox"/> Bacterial _____
<small style="margin-left: 100px;">(specify organism)</small> | <input type="checkbox"/> Fungal _____
<small style="margin-left: 100px;">(specify organism)</small> |
|---|--|

Antibiotics:

- Amphotericin (#doses) _____ (start date) _____
- Other _____ (start date) _____
 _____ (start date) _____

Patient Test Results	Date	Results
ABO/Rh Type		
Red Cell Antibody Screen		
Red Cell Antibody ID		
Absolute Granulocyte Count		

Acceptable Donor ABO/Rh Types O Positive A Positive B Positive AB Positive
 O Negative A Negative B Negative AB Negative

Initial number of Doses:

3 Days 5 Days Transfusion Start Date _____
(To order additional products call 215-451-4132 at least 24 hours in advance)

- Irradiated (by the American Red Cross)
- CMV-seronegative

Form completed by: _____ Date: _____

(please print: last name, first name)

Instructions to Complete the “Request for Granulocyte Products” Form

Please Print – Information Must Be Legible

Fax #: 215-451-2585

Phone 215-451-4132

Hospital Name/Code: enter hospital name and code
Ordering Physician/phone: enter name and phone number of physician ordering the product
Contact Person/phone: enter name and phone number of the person initiating the request

Patient Name: enter patient’s name (last name, first name)
ID Number: enter either hospital medical record number or patient’s social security number
Date of Birth: enter the patient’s date of birth (month/day/year)

Primary Diagnosis: enter the patient’s primary diagnosis
Transplant Performed: check (X) either ‘yes’ or ‘no’
If ‘yes’, enter date of transplant and identify type of transplant
Check (X) type of transplant
Enter transplant donor’s ABO/Rh

Infection: check (X) either ‘yes’ or ‘no’
If ‘yes’ check (X) to identify which type of infection

Antibiotics: check (X) and enter list of antibiotics the patient is receiving and date started

Patient Test Results: enter test date and test results for—
ABO/Rh; Red Cell Antibody Screen; Red Cell Antibody ID;
Granulocyte Count

Acceptable Donor Groups: enter ABO/Rh types that would be acceptable for transfusion

Initial Number of Doses: enter check (X) number of days product anticipated

Irradiated: enter check (X) if irradiation is required by American Red Cross

CMV: enter check (X) if CMV Negative product is required

Form Completed By: enter last and first name of person completing the form
Date: enter date that the form is being completed (month/day/year)

This completed form will be maintained in the patient's file indefinitely.