

# PENN-JERSEY REGION BLOOD PRODUCT REQUEST FORM

Please Fax Completed Form to: **(215) 451-2585**

Penn-Jersey Customer Service Phone: **(215) 451-4111**

Red Cross Hospital Code: \_\_\_\_\_

Hospital Staff Name: \_\_\_\_\_

Order Date: \_\_\_\_\_

Order Time: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Blood Bank Phone: \_\_\_\_\_

Blood Bank Fax: \_\_\_\_\_

Leukoreduced Red Blood Cells Request	Attributes Requested (Indicate by an "X")						ABO/Rh Blood Type - Indicate Number of Each Type Requested								Additional Attributes (Please specify)
	IRRD	CMVN	Hgb S-Negative	<6 Days Old	<14 Days Old	Multi Bags (4 or 7)	O POS	A POS	B POS	AB POS	O NEG	A NEG	B NEG	AB NEG	
Red Blood Cells															

Leukoreduced Platelet Pheresis Request (Single Donor / SDP)	Attributes Requested			ABO/Rh Blood Type - Indicate Number of Each Type Requested								Additional Attributes (Transfusion date)
	IRRD	CMVA	Any Type	O POS	A POS	B POS	AB POS	O NEG	A NEG	B NEG	AB NEG	
Platelets, Pheresis												

Leukoreduced Platelet Request (Random Donor / RDP)	Attributes Requested			ABO/Rh Blood Type - Indicate Number of Each Type Requested								Additional Attributes (Transfusion date)
	IRRD	CMVN	Any Type	O POS	A POS	B POS	AB POS	O NEG	A NEG	B NEG	AB NEG	
Platelets												

Red Cross Use Only
Staff Initials:
Hospital Staff:
Order Date / Time:
Transportation:
Order Number(s):

Frozen Product Request	ABO Type Indicate Number of Each Type Requested				
	O	A	B	AB	Any Type
Plasma Frozen <24 Hours (Product Code 18101)					
Fresh Frozen Plasma					
Fresh Frozen Plasma (Pediatric Aliquot)					
Other (Please specify)					
Cryoprecipitate (Product Code 10100)					

Delivery Request - Indicate by checking appropriate box(es)	<input type="checkbox"/> Next Scheduled (Routine) Delivery  <input type="checkbox"/> Unscheduled Delivery Product needed by: (Must indicate date and time) (SHP4 or SHP8)  Date: _____  Time: _____  <input type="checkbox"/> Urgent - Life Threatening (SHP1)
	<input type="checkbox"/> Red Cross to arrange transportation (SHP0)  <input type="checkbox"/> Hospital to arrange transportation (SHP9)

Hospital Use Only

CMVN, CMVA = Cytomegalovirus Sero-negative  
IRRD = Irradiated

American Red Cross Biomedical Services	Doc No W2022 21.4.frm012	Version 1.0
<b>Form: Penn-Jersey Region Blood Product Request Form</b>		

**What this form is about**

This form explains how Penn-Jersey Region hospital customers should complete a request for blood products and Penn-Jersey Region staff should document the processing of the product order.

**Who should use this form**

This form applies to Penn-Jersey Region hospital customers and staff who request and process blood product orders.

**Instructions - To Request Blood Products**

**1. COMPLETE THE "PENN-JERSERY REGION BLOOD PRODUCT REQUEST FORM"**

**A. Facility Information**

- 1) Record the Red Cross Customer Code and Hospital Name (if not already present).
- 2) Record the name of the Hospital Staff Name completing and submitting the request.
- 3) Record the date and the time the request form is being completed.
- 4) Record the telephone and FAX numbers to be used by the ARC to obtain additional information about the request and/or notify of status of request (if not already present.)

**B. Cellular Products**

The form includes three (3) sections: Leukoreduced Red Blood Cells (RBCs), Platelets, Pheresis (Single Donor, SDPs) and Platelets (Randoms, RDPs). Multiple cellular and frozen product categories can be requested on one form.

- 1) Indicate the attributes requested by an "X" in the applicable column.  
NOTE: For "Multi Bags" for RBCs, specify the number of bags by recording 4 or 7.
- 2) Indicate the number of products requested in the ABO/Rh type box.
- 3) Specify any additional attributes requested in the applicable column.
- 4) Indicate the transfusion date for Platelet products or if the products are for general inventory indicate "Inventory".
- 5) Additional lines are present in Leukoreduced RBCs, SDPs and RDPs sections for use when products with a different set of attributes are requested. Record the name of the product being requested.

**C. Frozen Products**

- 1) Indicate the number of products requested in the ABO type column.  
NOTE: One unit of "Pediatric Fresh Frozen Plasma" will consist of 3-4 small aliquot bags (depending on method of preparation).
- 2) If the frozen product requested is not on the list, e.g., Cryoprecipitate reduced Plasma, record the name of the product next to "Other" and indicate the number of products requested in the ABO type column.
- 3) If any ABO type of Cryoprecipitate is acceptable, indicate with an "X" in the applicable column.

**D. Delivery Request**

- 1) Check one of the boxes to indicate the delivery period requested: Next scheduled delivery, unscheduled delivery (date and time must be specified), or urgent, life-threatening situation.
- 2) If an unscheduled delivery is requested, check the applicable box to indicate if the ARC is to arrange transportation or if the hospital will arrange transportation.

**2. SUBMIT REQUEST**

Send completed request form by FAX transmission to **215-451-2585**.

**3. STATUS OF REQUEST**

An ARC representative is present at the FAX receipt area 24 hours a day/7 days a week to process requests. Upon receipt, an ARC representative will review the request form and place a return telephone call to the number indicated on the form to confirm receipt of the request and discuss product availability. Any modifications to the request will be documented by the ARC staff on the request form.

**Revision History**

Revision Number	Summary of Revisions
1.0	Initial Version in System 3 format. Converted from: <ul style="list-style-type: none"> <li>• Form21.4frm03.HS, American Red Cross (ARC) Blood Product Request Form dated 09/25/2006, and</li> <li>• and 21.4.frm03.HS – TU05-11, Blood Product Request Form: Product Request Checklist</li> </ul>

###