NOTE: PLEASE REFER TO THE BACK OF THIS REQUISITION FOR SPECIMEN HANDLING INSTRUCTIONS

MICHIGAN MEDICINE
PATHOLOGY - BLOOD BANK

BLOOD ORDER REQUISITION AND PHYSICIAN ORDERS

RESULTS REPORTING LOCATION CODE:

MRN:

NAME:

BIRTHDATE:

CSN:

☐ Routine
☐ STAT

ORDER DATE: _____ /_____ /_____ (mm/dd/yyyy)

ICD-10 Code/Diagnosis:	Ordering Clinician to receive report: ☐ See label above	
Collected by: (Signature Required)		___ ___ ___ ___ ___ UMHS Dr. #:
Collected Date: _____ /_____ /_____	Collection Time: _____:_____am/pm	Attending Physician: (if different from above) ___ ___ ___ ___ ___ UMHS Dr. #:

PATIENT TRANSFERRED TO UMHS FROM: _____ HISTORY OF ANTIBODIES: YES NO

PREVIOUS TRANSFUSIONS: YES NO PREGNANCY: YES NO

Instructions to person drawing and labeling the blood specimen: 1. **Identify patient** prior to collecting blood specimen. 2. **Match** labeled specimen **tubes** with **patient identification** before leaving the patient. 3. **Sign and date** the requisition. 4. **Sign and date** the specimen tube.

Refer to the on-line version of Blood Transfusion Policies https://www.pathology.med.umich.edu/blood-bank/blood-transfusion-policies

☐ TS, ITS (Type and Screen, Patient has Armband) P
☐ PTS, PTSI (Type and Screen, Preadmit for Surgery) P
☐ PTS3D (Type and Screen for Outpatient Transfusion) P
☐ ADM (Blood Type and Antibody Status, No Armband) P
☐ RH (Rh status) P
☐ BT (Blood Type) P
☐ RPBT (Confirmatory Blood Type-separate draw) P

☐ Transfusion Today Date/Time _____
☐ OR Today Time: _____
☐ OR Future Date: _____

☐ Summary Intraoperative Orders

Additional testing performed to resolve problems if needed.

All test and blood product orders should be placed in MiChart when possible. If the system is down, a signed requisition may be sent to tube station 158, or faxed to 6-6855.

Special Request: _____ Irradiated

#Units Product

___ Red Blood Cells (PRBC)
___ RBC - Volume _____ mL
___ Plasma (200 ml)
___ Plasma Volume _____ mL
___ Cryoprecipitated Antihemophilic Globulin (5 Unit Pool)
___ Cryoprecipitated Antihemophilic Globulin Single Units
___ ECMO Pack (Circle) Neonate Peds Adult
___ Trauma Pack (ED ONLY)
___ Massive Transfusion Pack

NOTIFY WHEN READY
PHONE:

#Vials/#Units Product

___ Apheresis Platelets
___ Platelets Volume _____ mL
___ Crossmatched Apheresis Platelets
___ HLA-Matched Apheresis Platelets
___ Rh Immune Globulin (IM 300 mcg)
___ Rh Immune Globulin (IV 300 mcg)
Wt. ____ kg Weeks Gestation _____
___ Other: _____

All Red Cells and Platelets are Leukocyte-reduced.

INFANT STUDIES

Infant is:
☐ Inborn
☐ Outborn (Indicate Hospital)
_____

(Submit Either Cord Blood or Venous Sample)
☐ Rh Immune Globulin Evaluation
☐ Jaundiced Infant Studies
☐ Mother Is Known To Have Antibodies

Mother's Name _____ Delivery:
Mother's Reg No. _____ Date: _____
Mother's ABO/Rh Type _____ Time: _____

ANTIBODY STUDIES

☐ Tranfusion Reaction Work Up P
☐ **DAT** Direct Antiglobulin Test 2P
☐ Red cell Antigen Typing
Indicate Antigens _____ P
☐ IgG Titer (Renal Protocol) P
☐ IgM Titer (Incompatible Heart Transplant) P
☐ Donath-Landsteiner Test (Blood Bank MD approval required) P,R (Special handling required)

☐ Crossmatch Platelet Testing 2P
Contact laboratory before collecting specimens
☐ **PINK** Specimens Requested by Blood Bank 2P
☐ **ISO** Isohemagglutinin Screen P
☐ **A1AG** Type A Subtyping P
☐ Other (Specify) _____

PRENATAL STUDIES

☐ AS Antibody Screen (ABID if positive) P
☐ ABID Mother is known to have antibodies P
☐ IgG Titer 2P
☐ PN ABO Group, Rh and Antibody Screen P
☐ OB OB Father and Probable Genotype of Father P

BMT WORK UP

☐ Pretransplant work up P
☐ Post Transplant work up P
☐ IgM/IgG Titer (Anti-A/Anti-B) P
☐ Blood Type (ABO/Rh) P
☐ Other (Specify)

Father's Full Name: _____ _____

FOR LABORATORY USE ONLY

DATE	BT	AS	TECH	DATE	BT	TECH

Antibody History BT on file Y ☐ N ☐

TELEPHONE ORDERS

DATE/TIME	OR/BS	AMT. PRODUCT	TECH.	COMPLETE (✔)

REQUEST FOR EMERGENCY RELEASE OF BLOOD COMPONENTS

(Complete only if units are requested prior to completion of required testing.)

I authorize and assume responsibility for the release of blood components without completion of required pretransfusion testing. Although transfusion of this blood may be associated with increased risk. I believe that delay of transfusion for completion of testing would seriously endanger the patient's life.

Signed: _____ MD/DDS Dr. Number _____

21-10049	VER: A/20 HIM: 08/20	LABORATORY	MICHIGAN MEDICINE UNIVERSITY OF MICHIGAN	TESTING / DIAGNOSTIC / SCREENING REQUISITION

Replaces: 2018032

SPECIMEN CODES:

TUBES

B = BLUE
F = FSP
G = GREEN
N = NAVY BLUE
L = LAVENDER
P = PINK
R = RED
S = SST (CORVAC)

SITE/MATERIAL

A = AMNIOTIC FLUID
BF = BODY FLUID
BM = BONE MARROW
CSF = SPINAL FLUID
GA = GASTRIC
M = MUSCLE TISSUE
SK = SKIN
T = TISSUE
U = URINE

HANDLING CODES:

BLACK REVERSE = SPECIMENS REQUIRE SPECIAL HANDLING. Refer to on-line handbook, "http://www.pathology.med.umich.edu/handbook/"

BLACK REVERSE ITALICS = SPECIMENS REQUIRE SPECIAL HANDLING AND A HISTORY AND DIAGNOSIS.

BLACK BOLD ITALICS = THESE TESTS REQUIRE A HISTORY AND DIAGNOSIS IN ORDER TO REPORT RESULTS.

COLOR BOLD ITALICS = THESE TESTS REQUIRE A SPECIAL CDC OR MDPH HISTORY FORM AVAILABLE IN THE LAB.

* = THESE TESTS INCLUDE A CONSULTATION AND REQUIRE A HISTORY AND DIAGNOSIS.

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BACK; HEAD TO HEAD