Ph. (206) 689-6525
Ph. (425) 688-5084
Ph. (425) 656-7900
Ph. (425) 434-4949
Ph. (206) 987-5151

CENTRAL
OVERLAKE TSL
SKL
EVERGREEN TSL
CHILDREN'S LAB

BloodworksNW

To reorder forms call 425-656-3019

PREADMISSION REQUEST FOR BLOOD

HOSPITAL | HOSPITAL NO.

PATIENT LAST NAME | FIRST | MIDDLE

SOCIAL SECURITY NO. | BIRTHDATE

BLOODWORKS
PREADMISSION REQUEST FOR BLOOD

PHYSICIAN REQUESTING BLOOD

DIAGNOSIS/PROCEDURE

☐ **PREADMISSION TYPE AND SCREEN**

☐ **PREADMISSION CROSSMATCH**

FOR HEMOSAFE CUSTOMERS:

☐ IF NOT ELECTRONIC CROSSMATCH(RA) ELIGIBLE, SEND:

OF UNITS ☐ RED BLOOD CELLS-LEUKOCYTE REDUCED

☐ IRRADIATED

PLANNED SURGERY

DATE	TIME

Have you been pregnant in the last 3 months? ☐ No ☐ Yes

Have you received a transfusion in the last 3 months? ☐ No ☐ Yes

X PATIENT (GUARDIAN) SIGNATURE

X PERSON COMPLETING REQUEST

X PERSON DRAWING BLOOD

X 2ND PERSON REVIEWING PATIENT ID (if required by hospital policy)

DATE DRAWN	TIME DRAWN

HISTORICAL BLOOD TYPE VERIFIED WITH BW?

If no historical blood type, send additional separately drawn specimen with BW confirmatory ABO/RH request.

☐ Historical blood type confirmed

☐ Confirmatory ABO/Rh to be collected

Comments

(2) 7 mL EDTA Specimens Required

19-9-169 04

BLOODWORKS USE ONLY

Tech ID	Timestamp

Patient History	ABO/Rh	Antibody (ies)	AHG XM required?	Triage Tech
		No	No	
		Yes	Yes	
Pre-Transfusion Testing	1st ABO/Rh	2nd ABO/Rh	Antibody Screen	
			Neg	
			Pos	
Computer X-Match Checks	1st ABO/Rh	2nd ABO/Rh	C-XM OK?	C-XM Tech
	DONE	DONE	No	
			Yes	

TRANSFUSED IN LAST 3 MONTHS? ☐ NO ☐ YES

TECH _____

DATE _____

BLOOD CENTER COPY

BloodworksNW

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PREADMISSION REQUEST FOR BLOOD

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			Yes	

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TECH _____

DATE _____

HOSPITAL COPY