689-6525 688-5084 656-7900 434-4949 987-5151	HOSPITAL HOSPITAL NO.  PATIENT LAST NAME FIRST MIDDLE			BLOODWORKS PREADMISSION REQUEST FOR BLOOD PHYSICIAN REQUESTING BLOOD					
Ph. (206) 6 Ph. (425) 6 Ph. (425) 4 Ph. (425) 4									
	SOCIAL SECURITY NO. BIRTHDATE			DIAGNOSIS/PROCEDURE					
		SSION TYPE AND	FOR HEMOSAFE CUSTOMERS:	BLOODWORKS USE ONLY					
GENTRAL OVERLAKE TSL SKL EVERGREEN TSL CHILDREN'S LAB	SCREEN		☐ IF NOT ELECTRONIC CROSSMATCH(RA) ELIGIBLE, SEND:	Tech ID	Timestamp				
	PREADMIS	SSION CROSSMATCH	# OF UNITS RED BLOOD CELLS- LEUKOCYTE REDUCED	Patient History	ABO/Rh	Antibody (ies)	AHG XM required?	Triage Tech	
A S S S S S S S S S S S S S S S S S S S			☐ IRRADIATED			No	No		
	PLANNED SURGERY			1	 	Yes	Yes	1	
	DATE	TIME	HISTORICAL BLOOD TYPE VERIFIED WITH BW?	Pre-	1st ABO/Rh	2nd ABO/Rh	Antibody Screen		
2				Transfusion Testing			Neg	1	
(SN)	Have you been pregnant in the last 3 months?   No Yes  Have you received a transfusion in the last 3 months?   No Yes		If no historical blood type, send additional separately drawn specimen with BW confirmatory ABO/RH request.				Pos		
BLOOD				Computer X-Match Checks	1st ABO/Rh	2nd ABO/Rh	C-XM OK?	C-XM Tech	
<u>т</u> Ш					DONE D	DONE	No		
3019 ST FO			Historical blood type confirmed		DONE	DONE	Yes		
5-656- QUES	X PATIENT (GUARDIAN) SIGNATURE		Confirmatory ABO/Rh to be collected						
all 42	X PERSON COMPLETING REQUEST		Comments						
To reorder forms call 425-656-3019  PREADMISSION REQUEST FOR BLOOD	X PERSON DRAWING BLOOD								
	X 2ND PERSON REVIEWING PATIENT ID (if required by hospital policy)								
	DATE DRAWN	TIME DRAWN		TRANSFUSED	IN				
о <b>д</b>			(2) 7 mL EDTA Specimens Required	LAST 3 MONTH	YES	TECH			
ĕ <b>L</b>			19-9-169 04				DATE		
						BLC	OOD CENT	ER COPY	

) 689-6525 ) 688-5084 ) 656-7900 ) 434-4949 ) 987-5151	HOSPITAL HOSPITAL NO.			BLOODWORKS PREADMISSION REQUEST FOR BLOOD					
Ph. (206) 6 Ph. (425) 6 Ph. (425) 6 Ph. (425) 4	PATIENT LAST NAME FIRST MIDDLE			PHYSICIAN REQUESTING BLOOD					
	SOCIAL SECURITY NO. BIRTHDATE			DIAGNOSIS/PROCEDURE					
		SION TYPE AND	FOR HEMOSAFE CUSTOMERS:	BLOODWORKS USE ONLY					
CENTRAL OVERLAKE TSL SKL EVERGREEN TSL CHILDREN'S LAB	SCREEN		☐ IF NOT ELECTRONIC CROSSMATCH(RA) ELIGIBLE, SEND:	Tech ID	Timestamp				
	PREADMISS	SSION CROSSMATCH	# OF UNITS RED BLOOD CELLS- LEUKOCYTE REDUCED	Patient History	ABO/Rh	Antibody (ies)	AHG XM required?	Triage Tech	
E S S S E			☐ IRRADIATED			No Yes	No Yes		
	PLANNED SURGERY		HISTORICAL BLOOD TYPE		4-4	-		<u> </u>	
	DATE	TIME	VERIFIED WITH BW?	Pre-	1st ABO/Rh	2nd ABO/Rh	Antibody Screen		
N <sub>V</sub>	Have you been pregnant in the last 3 months?		If no historical blood type, send additional separately drawn specimen with BW confirmatory ABO/RH request.	Transfusion Testing			Neg Pos	- -	
BLOOD				Computer X-Match Checks	1st ABO/Rh	2nd ABO/Rh	C-XM OK?	C-XM Tech	
ω ω ω					DONE	DONE	No		
3019 3 <b>T FO</b>			Historical blood type confirmed				Yes		
5-656- 2UES	X PATIENT (GUARDIAN) SIGNATURE		Confirmatory ABO/Rh to be collected						
all 424 N RE(	X PERSON COMPLETING REQUEST		Comments						
To reorder forms call 425-656-3019  PREADMISSION REQUEST FOR BLOOD	X PERSON DRAWING BLOOD								
	X 2ND PERSON REVIEWING PATIENT ID (if required by hospital policy)								
	DATE DRAWN	TIME DRAWN		TRANSFUSED	IN				
P. re			(2) 7 mL EDTA Specimens Required	LAST 3 MONTHS? \( \Boxed{\text{NO}}\) NO \( \Boxed{\text{YES}}\)			TECH		
<b>⊢ ⊡</b>			19-9-169 04				DATE		
						BLC	OOD CENT	ER COPY	

) 689-6525 ) 688-5084 ) 656-7900 ) 434-4949 ) 987-5151	HOSPITAL HOSPITAL NO.  PATIENT LAST NAME FIRST MIDDLE			BLOODWORKS PREADMISSION REQUEST FOR BLOOD PHYSICIAN REQUESTING BLOOD					
Ph. (206) 6 Ph. (425) 6 Ph. (425) 6 Ph. (425) 4 Ph. (206) 9									
	SOCIAL SECURITY NO. BIRTHDATE			DIAGNOSIS/PROCEDURE					
	1 1 1	SION TYPE AND	FOR HEMOSAFE CUSTOMERS:	BLOODWORKS USE ONLY					
CENTRAL OVERLAKE TSL SKL EVERGREEN TSL CHILDRENS LAB	SCREEN		☐ IF NOT ELECTRONIC CROSSMATCH(RA) ELIGIBLE, SEND:	Tech ID	Timestamp				
	PREADMISS	SSION CROSSMATCH	# OF UNITS RED BLOOD CELLS- LEUKOCYTE REDUCED	Patient History	ABO/Rh	Antibody (ies)	AHG XM required?	Triage Tech	
E E E E			☐ IRRADIATED			No Yes	No Yes		
	PLANNED SURGERY		HISTORICAL BLOOD TYPE	1	4-1		1	<u> </u>	
	DATE	TIME	VERIFIED WITH BW?	Pre-	1st ABO/Rh	2nd ABO/Rh	Antibody Screen		
MN <sub>S</sub>	Have you been pregnant in the last 3 months?		If no historical blood type, send additional separately drawn specimen with BW confirmatory ABO/RH request.	Transfusion Testing			Neg Pos	- - -	
BLOOD				Computer X-Match Checks	1st ABO/Rh	2nd ABO/Rh	C-XM OK?	C-XM Tech	
α π					DONE	DONE	No		
3019 <b>3T FO</b>			Historical blood type confirmed				Yes		
5-656- <b>2UES</b>	X PATIENT (GUARDIAN) SIGNATURE		Confirmatory ABO/Rh to be collected						
all 42! V REC	X PERSON COMPLETING REQUEST		Comments						
To reorder forms call 425-656-3019  PREADMISSION REQUEST FOR BLOOD	X PERSON DRAWING BLOOD								
	X 2ND PERSON REVIEWING PATIENT ID (if required by hospital policy)								
orde <b>ADI</b>	DATE DRAWN	TIME DRAWN	1	TRANSFUSED	IN				
RE,			(2) 7 mL EDTA Specimens Required	LAST 3 MONTHS? ☐ NO ☐ YES			DATEHOSPITAL COPY		
Ĕ <b>G</b>			19-9-169 04						