LifeStream
GIVE HOPE | GIVE LIFE | GIVE BLOOD

384 West Orange Show Rd • San Bernardino, CA • 92408
CLIA License #05D0575143

Attach BBID Sticker Here

REQUEST FOR TRANSFUSION OF BLOOD COMPONENTS

Patient's Last Name:	Patient's First Name:	
Patient's ID Number:	Date of Birth:	Gender: ☐ Male ☐ Female ☐ Not known
Transfusion Facility:	Diagnosis:	
Ordering Facility:	Transfusion History: ☐ No Transfusion History ☐ Unknown ☐ Within last 3 Months ☐ Prior to the last 3 Months	
Ordering Physician Name (Print):		
ABO/Rh(D) and/or Antibody History: (if known, submit laboratory report)	Facility of Last Transfusion: _____	

Specimen Collected By (PRINT NAME)	Date	Time		Date	Time
			Transfusion Scheduled		

Test Order

Type and Crossmatch: _____ Units	Number of Units: _____
☐ Red Blood Cells	☐ Apheresis Platelets
☐ Irradiated Red Blood Cells	☐ Irradiated Apheresis Platelets
	☐ Thawed Plasma (with LifeStream MD approval)

Pre - Transfusion Criteria

For Red Blood Cell Requests, Hgb: _____

If Hgb is 8.1-9.0 g/dl, please provide a clinical reason for transfusion: _____

_____

If Hgb is 9.1 g/dl or greater, please acquire LifeStream Medical Director approval:

Called to: _____ Name/Date/Time: _____

For Platelet Requests, Platelet Count: _____

If platelet count is 20,000 or higher, please acquire LifeStream Medical Director approval:

Called to: _____ Name/Date/Time: _____

Requested by (Print Name):	Date:
Comments:	

FOR REFERENCE LAB USE ONLY

☐ Pre-Transfusion Criteria Reviewed Tech Initials: _____ Date/Time: _____

Sample Received	
Date/Time	Initials

Sample Acceptable? ☐ Yes ☐ No, specify reason: _____

Notified: _____ Notified by: _____ Date/Time: _____

Submit the request to LifeStream
Retain a copy of request at Transfusing Facility