

GRANULOCYTE ORDER/CLINICAL HISTORY FORM

Patient Name: _____ MR #: _____
Sex: _____ Age: _____ Date of Birth: _____ Weight: _____ ABO/Rh Type: _____
Hospital: _____ Blood Bank Phone #: _____

Doses Requested: _____ *(Maximum 5 doses per order)*

Acceptable Donor ABO/RH Types: *(Check all that apply)* O+ O- A+ A- B+ B-

Frequency (Check one): Daily Every other day

- No Weekend or Holiday Collections
- Collections for orders received after 12 noon on Thursday, will begin no sooner than the next Tuesday

Other requirements: (NOTE: All granulocyte products are irradiated and non-leukoreduced)

Patient has RBC Antibody/ies (Which ones?): _____

NOTE: Granulocyte products require donor stimulation approximately 12-18 hours before collection. Typical time until first product availability is at least 2 business days.

Medical History

Diagnosis: _____

Type of infection and organism (if applicable): _____

Granulocyte indication (Additional information may be requested after blood center physician review):

- Severe neutropenia (ANC < 500/ μ l) and life-threatening bacterial or fungal infection not responsive to appropriate antibiotic/antifungal therapy
- Neonates with clinical sepsis and neutropenia (ANC < 1000/ μ l or < 3000/ μ l with evidence of diminished marrow neutrophil stores)
- Patients with infection and granulocyte function disorder

Renewing orders: Please contact the Special Services department at LifeStream if requesting to extend/renew order.

Canceling orders: You must notify LifeStream **IMMEDIATELY** if a patient is no longer in need of granulocyte transfusions. This will avoid unnecessarily stimulating a donor. Full charges will be applied for donors that are stimulated but not collected due to late notice and a cancellation fee may be applied for orders cancelled prior to stimulation.

Ordering Physician Name

Ordering Physician Contact Number

Ordering Physician Signature

Date

PLEASE FAX COMPLETED FORM TO (909) 386-6817 ATTN: SPECIAL SERVICES

Order Notes - LifeStream Use Only: _____

RELEASE REQUEST

Hospital: _____ Physician Name: _____ Fax: _____

Situation

UNIT # OR DONOR	COMPONENT	COMMENTS

I understand that the above unit/component does not meet routine release criteria for the following reason:

- Untested
- Partially tested
- Positive test result
- Improper storage conditions
- Production problems
- Other:

I realize that due to the conditions of release of the unit, it is to be transfused only to:

Intended Recipient Name: _____
 Date of Birth: _____
 Medical Record #: _____
 OR
 Social Security #: _____

Physician Release and Signature

 Because of the unique nature of the component, I request the **release** of the unit(s)/component(s) listed above. I understand a medical director from LifeStream has approved the release for this patient.

Physician Refusal and Signature

 Despite the unique nature of the component, I request the **disposal** of the unit(s)/component(s) listed above. I understand the listed units will be **unavailable** for transfusion for the above listed patient.

 Other processing requests or additional information: _____

 Physician Name: _____ Signature: _____
 Please Print or Type

Telephone: _____

PLEASE RETURN FAX TO:

(909) 386-6817 ATTN: Medical Surveillance/ Special Services

Fax by: _____ Returned: _____

RELEASE REQUEST

Hospital: _____ Physician Name: _____ Fax: _____

Situation

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