

GRANULOCYTE ORDER/CLINICAL HISTORY FORM

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

NOTE: After this order is received, it will take at least 2 business days before the first product is available. All granulocyte products are irradiated and non-leukoreduced, collected from stimulated donors.

Doses Requested: _____ (Maximum 5 doses per order)

Acceptable Donor ABO/RH Types: (Check all that apply)

☐ O+ ☐ O- ☐ A+ ☐ A- ☐ B+ ☐ B- ☐ AB+ ☐ AB-

CMV: Lifestream does not routinely provide CMV negative granulocytes. Check box (below) to limit donors to CMV negative only. ☐ *NOTE: This may delay product availability significantly.*

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

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

Patient Diagnosis: _____

Infection Type 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

Extending orders: Please contact the Special Services Dept. at LifeStream if requesting to extend 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.

 Transfusion Service or Ordering Physician Name

 Physician Contact Number

 Transfusion Service or Ordering Physician Signature

 Date

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

Lifestream Use Only: Extension Requests			
# Collections	Requested by:	License Initials	Date

GRANULOCYTE COMPONENTS RELEASE FORM

Granulocyte Patient Recipient:

Patient Name: _____ MR #: _____

Date of Birth: _____ Hospital: _____

Transfusion Service Physician's Consent for Release of Granulocytes to Requesting Facility

My signature below indicates that I agree with all of the following statement:

- *“Given the unique nature of granulocyte components and the urgency of the clinical situation, I give approval for release of these untested products to my facility. I affirm that my facility will fulfill all applicable AABB and CFR standards and regulations regarding the transfusion of untested products, including the required signed statement in my facility’s medical record by the requesting physician.”*

Transfusion Service Physician Name: _____ Phone Number: _____

Transfusion Service Physician Signature: _____ Date: _____

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