Simulated Blood Bank Order

Nursing

Requesting Physician	Order Date	Written By	Order Time	Time In	Time Out

Please Send One Slip For Each Unit Ordered

☐ Type and Screen Only
☐ Crossmatch

☐ To be Given — Date — Time

☐ For Surgery at — Date — Time

☐ **STAT** (To be Transfused Immediately)
☐ **STAT** (Crossmatch Only)

☐ Yes ☐ No Previous Transfusion?
☐ Yes ☐ No Previous Transfusion Reaction?

Diagnosis

Blood Product Requested

☐ Packed Red Cells
☐ Fresh Frozen Plasma
☐ Platelet Pheresis
☐ Platelet Concentrate ____ #
☐ Cryoprecipitate ______ #
☐ Rhogam
☐ Washed Cells
☐ Frozen Cells
☐ Other ______
☐ Autologous (Specify) ______
☐ Recipient – Specific ______

Special Considerations

☐ Leukopoor ☐ Irradiated

☐ CMV Negative ☐ Aliquot cc ______

☐ Other ______

I have taken a blood specimen on the named patient below, verified the name, verified the specimen tube label (and placed armband on patient if applicable).

Signature ____________________ Date __________ Time __________

Emergency Release: Due to the critical condition of this patient, I request the immediate release of blood for emergency transfusion without (crossmatch) (complete crossmatch) or other tests of compatibility. I assume complete responsibility for any resultant untoward reaction or injury to my patient.

Physician's Signature ____________________ Date __________ Time __________

Laboratory

Blood Type, Compatibility Information

BBK ID No.	**Crossmatch:** ☐ Compatible ☐ Not Compatible ☐ Compatibility Tests **Not Performed** (Explain below) ☐ Compatibility Tests **Not Required** (Explain below) ☐ History Check Performed	Unit No.
Recipient Group & Type		Donor Group & Type
Antibody Screen	Remarks	Component
ABID		Exp. Date
Signature (person performing tests)	Date/Time	Total Volume

Nurse Receiving Unit - Signature	Tech. Releasing Unit - Signature	Date/Time	Appearance Checked
Nurse Returning Unit - Signature	Tech. Receiving - Signature	Date/Time	Temp. Checked
Nurse Reissue - Signature	Tech. Releasing - Signature	Date/Time	Appearance Checked

Nursing

Must be verified by (2) Nurses Prior to Transfusion **Record of Transfusion**

I certify that the identity of this recipient and of this donor blood (or blood product) have been confirmed, item by item, and have found no discrepancy with the compatibility label for simulated blood attached to this unit.

Transfusionist sign – Nurse 1	Nurse 2	Date	Time

	Temp.	**BP**	**Pulse**	**Respirations**
Pre-Transfusion		/	/ min.	/ min.
15 min. after start of transfusion		/	/ min.	/ min.
Post-Transfusion		/	/ min.	/ min.

Transfusion Started Date/time	Transfusion Ended By Date/Time	Volume Given

Recipient Response To Transfusion

☐ No Reaction ☐ Fever ☐ Headache ☐ Nausea
☐ Chills ☐ Urticaria ☐ Back Ache ☐ Nausea or Vomiting
☐ Dyspnea ☐ Other ______

☐ Yes ☐ No Empty Blood Bag Returned to Blood Bank

☐ **Yes** ☐ **No** **Reaction Form Initiated**

Nursing Remarks

PATIENT IDENTIFICATION