American Red Cross Biomedical Services
Washington, DC 20006

Business Form: Donor Request for Special Blood

Fax or e-mail to:  
Fax 215-451-2585  
Phone 215-451-4111  
Address Penn-Jersey Region 700 Spring Garden Street Philadelphia, PA 19123

Information Provided by the Requesting Facility (SEE PAGES 2 OR 3 FOR MULTIPLE ORDERS)

Facility: ____________________________  
Phone: ____________________________  
Fax: ____________________________

Account number: ____________________________  
Contact person/ date/ time of request: ____________________________

When needed (✓ box that applies):

☐ Pre-op; surgery date: ____________________________
☐ Routine; date/time: ____________________________
☐ Urgent (within 24 hr)
☐ Critical (within 12 hr)
☐ Emergency (within 6 hr)
☐ Life threatening (must call Reference Lab)

Comments/ detail how units should be shipped:

Patient Name: ____________________________  
ABO/ Rh: ____________________________

Fill in # needed: ______ RBC  ____ PLASMA  ____ PLATELET  Other:

Special requirements (Circle all that apply).  
HgbS  ______  CMV  ______  Irradiated  Washed  Type Specific  Other:

Antigen Negative for (Circle all that apply):

C  c  E  e  K  k  Fya  Fyb  Jka  Jkb  M  N  S  s  Lea  Leb  Other:

To Be Completed By the American Red Cross

Order receipt date: ____________________________  
Time: ____________________________  
Received By (initials): ____________________________  
Comments (date/initial comments): ____________________________

ABO/ Rh (indicate #)  
Order by: ____________________________  
Modifiers (Circle all that apply):  
CMV  IgA

Service fees (Circle all that apply, add others as needed)  
MODIFIER

DI N/ WBN Sent

Hospital Services Order #  
Filled by: ____________________________  
Shipment #

American Red Cross Biomedical Services
Process Owner: Senior Director, Immunohematology Reference Laboratory
Legacy Doc No: 16.4.frm073 v-0.7
American Red Cross Biomedical Services  
Washington, DC 20006  

**Business Form: Donor Request for Special Blood**

Request for Leukoreduced RBCs for Chronically Transfused Patients—by inventory need

Fax or e-mail to: Fax 215-451-2585  
Phone 215-451-4111  
Address Penn-Jersey Region 700 Spring Garden Street Philadelphia, PA 19123

<table>
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<th>Phone:</th>
<th>Date needed</th>
<th>Comments/detail how units should be shipped:</th>
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## Business Form: Donor Request for Special Blood

**Request for Leukoreduced RBCs for Chronically Transfused Patients—by day of week**

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