Special Unit Request Form

Requesting Facility _______________________________________________________

# of Units______________     ABO/Rh (or compatible) ___________ ___

	**ALL ORDERS MUST BE CALLED IN BEFORE FAXING**

Priority:     __________STAT               _________Routine

Date/Time needed for transfusion/surgery:

Antigen Negative For:

___C     ___Fya     ___M     ___Lea     ___P1
___c     ___Fyb     ___N     ___Leb     ___Cw
___E     ___Jka     ___S     ___K     ___
___e     ___Jkb     ___s     ___k     ___

Other Testing Required:

___Sickle Cell Negative     ___Leukoreduced     ___CMV Negative     ___Irradiated

Additional Requirements: _________________________________________________
________________________________________________________________________

Ordered By: _______________ Phoned to: ___________________________

Date: ______________ Time: _______________________________________

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