

LifeStream Blood Bank

Date of Request:		Name:			
Comments:		ID Number:			
		Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Draw Date: Time: Initials:		Sample Number:		Sample Type: # Submitted <input type="checkbox"/> K2E _____ <input type="checkbox"/> Serum _____	
Authorizing M.D.: Santiago Castillo Jr., M.D. <input type="checkbox"/> Other					
SUBMITTING FACILITY (√) :		REPORT RESULTS TO (√) :			
Facility: _____ <input type="checkbox"/> Apheresis <input type="checkbox"/> Medical Surveillance <input type="checkbox"/> Human Resources <input type="checkbox"/> LLUMC <input type="checkbox"/> Other _____ _____		Facility: _____ <input type="checkbox"/> Apheresis <input type="checkbox"/> Medical Surveillance <input type="checkbox"/> Human Resources <input type="checkbox"/> OTHER _____ Address: _____ _____			
Testing Requested					
<input type="checkbox"/> Complete Donor Panel (ABO/Rh, antibody screen, Syphilis, viral markers)		Laboratory Testing	Result	Date	Initials
		<input type="checkbox"/> CMV			
<input type="checkbox"/> Donor Panel – Pre-Screen Granulocyte		<input type="checkbox"/> DAT			
<input type="checkbox"/> Offsite Testing Panel (External Customers Only)		<input type="checkbox"/> Cold Agglutinin			
<input type="checkbox"/> Pre-Platelet Count DO NOT REFRIGERATE		<input type="checkbox"/> Other:			
<input type="checkbox"/> CBC (Complete Blood Count) DO NOT REFRIGERATE					
<input type="checkbox"/> Anti-HBs (Employee Post-vaccination)					
Received		Comments:			
Date					
Time					
Initial					

Time Date Stamp