LifeStream
GIVE HOPE | GIVE LIFE | GIVE BLOOD

GRANULOCYTE ORDER/CLINICAL HISTORY FORM

Patient Name: _____ MR #: _____

Sex: _____ Age: _____ Date of Birth: _____ Weight: _____ ABO/Rh Type: _____

Hospital: _____ Blood Bank Phone #: _____

Doses Requested: _____ ***(Maximum 5 doses per order)***

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*

Other requirements: (NOTE: All granulocyte products are irradiated and non-leukoreduced)

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

NOTE: Granulocyte products require donor stimulation approximately 12-18 hours before collection. Typical time until first product availability is at least 2 business days.

Medical History

Diagnosis: _____

Type of infection and organism (if applicable): _____

Granulocyte indication (Additional information may be requested after blood center physician review):

☐ Severe neutropenia (ANC < 500/µl) and life-threatening bacterial or fungal infection not responsive to appropriate antibiotic/antifungal therapy

☐ Neonates with clinical sepsis and neutropenia (ANC < 1000/µl or < 3000/µl with evidence of diminished marrow neutrophil stores)

☐ Patients with infection and granulocyte function disorder

Renewing orders: This form is only required with the initial order. If a renewal/extension of this order is requested, please contact LifeStream Medical Director.

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.

_____ _____

Ordering Physician Name | Ordering Physician Contact Number

_____ _____

Ordering Physician Signature | Date

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

Order Notes - LifeStream Use Only: _____

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TRANSFUSION SERVICE DIRECTOR

RELEASE REQUEST

Hospital:_____ Physician Name:_____ Fax:_____

Situation

UNIT # OR DONOR	COMPONENT	COMMENTS

I understand that the above unit/component does not meet routine release criteria for the following reason:

- ☐ Untested
- ☐ Partially tested
- ☐ Positive test result
- ☐ Improper storage conditions
- ☐ Production problems
- ☐ Other:

I realize that due to the conditions of release of the unit, it is to be transfused only to:

Intended Recipient
Name:
Date of Birth:
Medical Record #:
OR
Social Security #:

☐ **Physician Release and Signature**
Because of the unique nature of the component, I request the **release** of the unit(s)/component(s) listed above. I understand a medical director from LifeStream has approved the release for this patient.

☐ **Physician Refusal and Signature**
Despite the unique nature of the component, I request the **disposal** of the unit(s)/component(s) listed above. I understand the listed units will be **unavailable** for transfusion for the above listed patient.

Other processing requests or additional information:_____

_____

_____

Physician Name:_____ Signature:_____
Please Print or Type

Telephone:_____

PLEASE RETURN FAX TO:

☐ **(909) 386-6817 ATTN: Medical Surveillance/ Special Services**

Fax by:_____ Returned: _____

384 W. Orange Show Road, P.O. Box 1429, San Bernardino, CA 92412-5729 • Tel: 909.885.6503 • Fax: 909.386.6817

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ATTENDING PHYSICIAN

RELEASE REQUEST

Hospital:_____ Physician Name:_____ Fax:_____

Situation

UNIT # OR DONOR	COMPONENT	COMMENTS

I understand that the above unit/component does not meet routine release criteria for the following reason:

- ☐ Untested
- ☐ Partially tested
- ☐ Positive test result
- ☐ Improper storage conditions
- ☐ Production problems
- ☐ Other:

I realize that due to the conditions of release of the unit, it is to be transfused only to:

Intended Recipient
Name:
Date of Birth:
Medical Record #:
OR
Social Security #:

☐ **Physician Release and Signature**
Because of the unique nature of the component, I request the **release** of the unit(s)/component(s) listed above. I understand a medical director from LifeStream has approved the release for this patient.

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Other processing requests or additional information_____

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Physician Name:_____ Signature:_____
Please Print or Type

Telephone:_____

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Fax by:_____ Returned: _____