Red Cells Order Form

Hospital: _____________________________  City/Town: ________________

Completed By: ______________________  Phone Number: _____________

Date Completed: _____________________  Time: _____________________

Priority:  □ Routine  □ Stat (Stat orders must be faxed and phoned)

Delivery Mode of Transportation: _______________________________________

Date Required: ________________  Time Required: ________________

<table>
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<tr>
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<th>O POS</th>
<th>A POS</th>
<th>B POS</th>
<th>AB POS</th>
<th>O NEG</th>
<th>A NEG</th>
<th>B NEG</th>
<th>AB NEG</th>
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<tbody>
<tr>
<td>Stock no modifiers</td>
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<td>Stock Irradiated Only</td>
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<td>Stock Neonatal Divided • Non-irradiated</td>
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</tbody>
</table>

For Crossmatch Use Only:

Name of Transport Person Notified: ____________________  Time Order Needed by Transport: __________

Packing Slip #(s): ________________________________  Initials: ____________

Comments:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________