Patient Sticker

Cayuga HEALTH

Special Transfusion Requirements Requisition

Patient Name: _____ Date/Time: _____

Date of Birth: _____

Requesting Provider: _____

Signature: _____

Note: A CHOA Provider or Pathologist must be consulted if requesting outside established criteria.

Please select all that apply:

☐ Antigen Matched
- o Patient is on Medication that interferes with testing (Daratumumab/ Darazalex, Isatuximab)
  - ✓ Send an EDTA sample to the blood bank **before** the patient begins treatment
  - ✓ Patient will begin this treatment on: _____
- o Sickle Cell Disease or Thalassemia

☐ Irradiated (Psoralen treated for Platelets)
- o Indicated for patients at risk for graft-vs-host disease who include:
  - Bone marrow transplant
  - Severe congenital or acquired immunodeficiency
  - Lymphoma/leukemia
  - Neonates less than 1500 g

☐ CMV Negative (Psoralen Treated for Platelets)
- o Allogeneic bone marrow, heart, or lung transplant/candidate AND CMV seronegative
- o Acute leukemia AND CMV seronegative
- o Pregnant AND CMV seronegative
- o Low birthweight neonate

☐ Hemoglobin S Negative
- o Patient has Sickle Cell Disease

☐ Split Unit
- o Patient is fluid Sensitive (Cannot withstand 350mL of blood products in 4hrs)
- o Patient has congestive heart failure
- o Infant

Other: _____

_____

Indication: _____

_____

Consulted with (if indication is outside established criteria): _____

_____

Send the completed form to the Blood Bank. Fax: 607-252-3201