

Reference & Transfusion (R&T) Services
GRANULOCYTE PRODUCT ORDER & PHYSICIAN RELEASE FORM

Instructions:

1. **Prior to completing this form:** Call the Carter BloodCare (CBC) Medical Director On-Call at **817-482-9446**.
2. Once approval has been obtained from the CBC Medical Director, document all required information in the "Patient Information" and "Hospital Information" sections below.
3. The ordering physician **must** read the statement below, sign and date the order/release form. Signature stamps are **not** acceptable. The order will be rejected without a handwritten signature from the ordering physician.
4. Once all required fields of the form are completed, fax it to the R&T Services Department at **817-412-5749**.
5. Notify your hospital Blood Bank of the granulocyte order so they will be expecting this product from CBC.
6. Notify CBC Medical Director On-Call **STAT** if the order is to be canceled early.

PATIENT INFORMATION

Patient Name:		Medical Record ID#:		Order Date:	
Patient Weight:		Patient ABO/Rh:		Date of Birth:	
Is Patient Taking Antifungal Medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	NOTE: There should be a 6 – 8 hour difference between dose of medication & transfusing of granulocyte product.	CMV Status:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
Indication for Granulocytes:	<input type="checkbox"/> Bacterial sepsis with neutropenia <input type="checkbox"/> Fungal sepsis with neutropenia <input type="checkbox"/> Other: _____				
# of Days Product Needed:	NOTE: To guarantee granulocyte product yield, at least 48 hrs. must be allowed between order date and start date.				

HOSPITAL INFORMATION

Hospital Name:		Component Requested:	<input type="checkbox"/> Granulocyte <input type="checkbox"/> Buffy Coat
Hospital Blood Bank Phone #:		Hospital Blood Bank Contacted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ordering Physician Name:		Ordering Physician Phone Number:	

NOTE: Products prepared by cytopheresis may be unlicensed products. The collection, release and transfusion of the product requested above has been deemed necessary as a life-saving measure and must be released emergently.

Medical Necessity Documentation (Completed by Attending Physician):

I certify that the product(s) indicated above is medically necessary for the treatment of this patient named above. I understand that the product(s) may be delivered immediately after collection and before infectious disease testing of the collected product(s) has been completed, and that this deviates from the regulations required by *FDA (21 CFR 606.171[b])*. However, the status of the patient's condition dictates that the product(s) indicated above is needed with sufficient urgency and the benefits of the product(s) being transfused outweigh the risk(s) involved. I understand that close monitoring of this patient for transfusion – associated adverse events should still occur per the transfusion facility's blood administration policy.

Physician Signature:	Date:
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****CARTER BLOODCARE R&T USE ONLY****

Received By CBC R&T Tech Initials / ID#:	Date/Time Received:	Sent to CBC MD On-Call?	<input type="checkbox"/> Yes	Date / Time:
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Document Product Issue & Delivery to Distribution Below: