The Blood Center
Reference Laboratory

2609 Canal Street
New Orleans, La. 70119

Phone (504) 592-1569
Fax # (504) 592-1570

Special Unit Request Form

*****ALL ORDERS MUST BE CALLED IN BEFORE FAXING*****

Requesting Facility _____

Order for: **Patient Specific Use:** _____ **Inventory Order:** _____
If patient specific, please complete patient name, medical record number, and hemoglobin information.

Patient Name: _____ **MR:** _____ **Hgb:** _____

# of Units_____ **ABO/Rh (or compatible)** _____

Priority: **STAT** _____ **Routine** _____

Date/Time needed for transfusion/surgery: _____

Antigen Negative For:

___C	___Fya	___M	___Lea	___P1
___c	___Fyb	___N	___Leb	___Cw
___E	___Jka	___S	___ K	___ _____
___e	___Jkb	____s	___ k	___ _____

Other Testing Required:

____Sickle Cell Negative **____ Leukoreduced** **____CMV Negative** **____Irradiated**

Additional Requirements: _____

_____

Ordered By: _____ **Phoned to:** _____

Date: _____ **Time:** _____

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