vitalant℠

Center Information:

Granulocyte Request and Recipient History

Patient Name _____ Med Record Number _____

Date of Birth _____ Weight _____ Gender _____

Hospital _____

Blood Bank Phone Number _____ Ward/Unit Phone Number _____

Granulocytes will not be available for distribution for at least 24 hours from the time the blood center receives the request.

NOTE: All granulocyte orders require review of this form and approval by the Medical Director. Additional clinical information may be requested.

Indications for urgent medical need of granulocytes (Check below):

☐ Severe Neutropenia (ANC < 500/μL) and life-threatening bacterial or fungal infection not responsive to appropriate antibiotic/anti-fungal therapy
- The patient should have a possibility of survival for > 48 hours from the time of placing the collection order.

☐ Neonates: Clinical evidence of profound sepsis and an absolute neutrophil count < 1,000/μL.

☐ Patients with infection and granulocyte function disorder.

☐ Other, explain: _____

Medical History

Diagnosis _____

Most recent White Blood Cell Count (WBC/μL) _____ Date _____

Most recent Absolute Neutrophil Count (ANC/μL) Date _____

Blood Type _____ CMV Status, if known _____ Red Cell Antibody _____

Type of infection and organism (if applicable) _____

Anticipated frequency of granulocyte transfusions: ☐ Every day ☐ Every other day ☐ Other _____

Anticipated number of transfusions: _____ **Note: Re-assessment and consultation are required after 5 Granulocytes.**

Special Attribute Requirements (Check if applicable):

☐ Receiving facility will perform irradiation ☐ Specific blood types accepted post-transplant

☐ CMV negative ☐ Will accept CMV antibody positive.

☐ Other _____

Canceling orders: Because granulocyte donors are stimulated the day preceding collection with medication (G-CSF and/or steroids), the blood center must be notified **IMMEDIATELY** if a patient is no longer in need of granulocyte. A cancellation fee will be applied for donors that are stimulated but not collected due to a late cancellation.

In order to provide the requested granulocytes, this product will be released for use prior to completion of laboratory testing, including infectious disease testing required by the Food and Drug Administration (FDA). As the physician caring for this patient, I understand the inherent risks and authorize the release of the requested granulocytes to the transfusion service facility. The transfusion service facility and physician accept full responsibility for the blood components and release Vitalant of any liability for medical complications resulting from the transfusion of the blood components prior to the completion of laboratory testing.

Ordering Physician Name _____ Phone Number _____

Ordering Physician Signature _____ Date _____

For Internal Use Only – Medical Director Recipient Approval

Medical Director Name _____ Date contacted _____ EC _____

Verbal Approval ☐ NA ☐ Yes ☐ No Comments: _____

Medical Director Signature _____ Date _____