Kaleida Health

Patient Name _____

Date of Birth _____ Admission/Visit Date _____ Site _____

Medical Record Number _____ Financial Number _____

Patient ID Area

EMERGENCY BLOOD RELEASE FORM

COMPLETE FORM AND BRING TO LAB. COMPLETED RECORDS ARE TO BE RETURNED TO THE BLOOD BANK.

TO BE COMPLETED BY REQUESTING LOCATION

RED BLOOD CELL UNITS REQUESTED ARE:

☐ Uncrossmatched, O Negative

☐ Uncrossmatched, ABO & Rh Compatible

☐ Uncrossmatched, Antibody Present

☐ Crossmatch Incompatible, Unidentified Antibody Present

☐ Crossmatch Compatible, Unidentified Antibody Present

☐ _____

If the request above is unclear, **ONLY UNCROSSMATCHED, O NEGATIVE** *units will be supplied while the order is clarified.*

The clinical status for the above-named patient necessitates this request prior to the beginning, or completion of the required laboratory tests. With full knowledge of the potential risks please release _____ units of red blood cells.

_____
Requesting Location

_____
Physician *Print Name*

_____ _____ _____
Date   Time   Physician *Signature*

TO BE COMPLETED BY LABORATORY							
Unit Number	**ABO, Rh Group**	**Issued By**			**Testing Completed By**		
		Tech	**Time**	**Date**	**Tech**	**Time**	**Date**

NOT PART OF PERMANENT MEDICAL RECORD

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CONSENT