



970 Linwood Avenue West, Paramus, NJ 07652
 Reference Laboratory Phone: 201-251-3975 Fax: 201-670-6174

Antigen Negative Unit Requisition Form

Patient Information			
ABO/ D Type	Number of Units	Name (Last, First)	Date of Birth

Hospital	Phone

Requested	
Date: Time:	By (Hospital Staff):

Antigen Negative Requirements (Indicate by Circling Antigen(s))						
(Big C) C	E	(Little c) c	e	(Big K) K	Fy^a	Fy^b
(Big S) S	(Little s) s	Jk^a	Jk^b	M	C^w	Kp^a
Other Antigen:	Other Antigen:	Other Antigen:	Other Antigen:	Other Antigen:	Other Antigen:	Other Antigen:

Other Product Attributes (Check Appropriate Box)	
<input type="checkbox"/> Leukoreduced	<input type="checkbox"/> Group "O" Acceptable
<input type="checkbox"/> Sickle Cell Negative	<input type="checkbox"/> ABO/D Specific ONLY
<input type="checkbox"/> CMV Negative	<input type="checkbox"/> Non-Leukoreduced units acceptable
<input type="checkbox"/> Washed	<input type="checkbox"/> D+ (Rh positive) acceptable
<input type="checkbox"/> Irradiated	<input type="checkbox"/> Fresh: Less than _____ days old
<input type="checkbox"/> Frozen/Thawed Units OK	<input type="checkbox"/> Other/Comments:

Transfusion Information	
<i>(Indicate by Checking Box that Applies and Enter Information as Applicable)</i>	
<input type="checkbox"/> Routine <input type="checkbox"/> ASAP <input type="checkbox"/> Stat	Units Needed By: _____

(CBS Staff Use)

Request Received by: _____ Date: _____ Time: _____



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Instructions for Antigen Negative Unit Requisition Form

NOTE: Staff from client hospitals will complete this form and fax to laboratory

ABO/D Type	Document patient's ABO/D type.
Number of Units	Document number of units needed for patient's transfusion.
Name (Last, First)	Document correct spelling of patient's name.
Date of Birth	Document patient's date of birth.
Hospital	Document name of hospital that ordered request.
Phone	Document hospital phone number.
Date: Time:	Document date and time order was requested.
By (<i>Hospital Staff</i>):	Document name of hospital staff ordering RBCs.
Antigen Negative Requirements	Circle the appropriate antigen negative requirements.
Other Antigen:	Indicate other antigens not listed on form, if applicable.
Other Product Attributes	Check appropriate box(es).
CBS Staff Name	Document name of CBS staff notified
Date/Time Notified	Document date and time notified
Transfusion Information	Check appropriate box relating to urgency of units.
Units Needed By:	Indicate date when unit is needed.
Received by:	Document name of staff who received order.
<i>CBS Staff shall document:</i> Date: Time:	Document date and time order was received.