**Instructions:** E-mail completed form to HPC@innovativeblood.org.

**IBR staff will follow up with the Coordinator listed below when donor is scheduled.**

**NOTE: Granulocyte products will be shipped prior to completed testing. Ordering Physician will be notified of any reactive test results.**

**Patient Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name | MI | Last Name | Birthdate | Gender[ ]  M [ ]  F |
| Address | City | State | Zip Code |
| Patient’s Contact Person (if not patient) | Phone # |
| Diagnosis | Patient’s ABO/Rh |
| Hospital Name | Hospital Address | City and State |

**Physician’s Order:**

|  |  |  |
| --- | --- | --- |
| **Product Specifications** | [ ]  ABO Type Identical[ ]  ABO Type CompatibleMark acceptable ABO Type(s) [ ]  A [ ]  O [ ]  B [ ]  AB | [ ]  CMV Negative[ ]  Irradiated  |
| **Collection Specifications** | Date product requested - FIRST date: \_\_\_\_\_\_\_\_\_\_ LAST date: \_\_\_\_\_\_\_\_\_\_ Frequency: [ ]  Daily [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Total # of collections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Ordering Physician Information:**

|  |  |  |
| --- | --- | --- |
| Physician Name | Phone | Fax |
| Address | City | State | Zip Code |
| Email |
| Physician Signature |
| Nurse/Coordinator: | Nurse/Coordinator Phone # |

CONTACT:

Monday-Friday, 7:00 am-3:30 pm: Innovative Blood Resources, Cellular Therapy staff, 651-332-7193

Weekends and after hours: Innovative Blood Resources, 651-332-7108 (ask to have the IBR physician on call contacted)