**Instructions:** E-mail completed form to [HPC@innovativeblood.org](mailto: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 Compatible  Mark 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)