Center Information:

Granulocyte Request and Recipient History

Patient Name ______________________ Med Record Number ______________
Date of Birth ______________________ Weight __________
Hospital ______________________ Blood Bank Phone Number ______________
Ward/Unit ______________________ Ward/Unit Phone Number ______________
Ordering Physician ______________________ 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):

☐ Adults: 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 screen ______________
Type of infection and organism (if applicable) ______________________
Current antibiotic and/or antifungal therapy: ______________________
Anticipated frequency of granulocyte transfusions: ☐ Everyday ☐ Every other day ☐ Other __________
Anticipated number of transfusion ______________________

Special Attribute Requirements (Check if applicable):

☐ Receiving facility will perform irradiation
☐ CMV Negative
☐ Specific blood types accepted post-transplant ______________________
☐ 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.

____
Ordering Physician Name

______________________ ______________
Ordering Physician Signature Date

For Internal Use Only – Medical Director Recipient Approval

Medical Director Name ______________ Date contacted ______________ EC ______
Verbal Approval ☐ NA ☐ Yes ☐ No Telephone Conversation ______________________

____

Medical Director Signature ______________________ Date ______________