Pharmaceutical Product Order Form

Hospital Services Department

BLOODCENTER of WISCONSIN™

Facility ordering product: Fax the completed form to the BloodCenter distributor location that will be supplying your order: *Milwaukee:* (414) 933-7350 *LaCrosse*: (608) 782-4489 *Marshfield*: (715) 384-7907

Hospital Name or Abbreviation:			Name of Hospital Staff Placing Order:
Delivery: ☐ Routine ☐ Need by date/time:_____ ☐ STAT (BCW use only: ETA:)	Date Ordered:	Time Ordered:	BCW Order Received by:
PO #: (if applicable)	Phone Number:	Delivery Directions : (if applicable)	

PRODUCT	QUANTITY	PRODUCT	QUANTITY
☐ Benefix		☐ Novo-7 RT	____ 1.0 mg ____ 2.0 mg ____ 5.0 mg
☐ Helixate		☐ Kcentra	____ 500 IU ____ 1000 IU
☐ Humate-P		☐ Other:	
☐ Kogenate			
☐ Advate			
☐ Thrombate III			
Comments:			

FOR BLOODCENTER USE ONLY

(Complete this section only when there are changes to the order)

Hospital Contacted By:	Date:	Time: