SPECIAL PRODUCT REQUEST FORM

Apply the recipient's demographic information label in this space, OR attach demographic information sheet to the form.

PLEASE PRINT OR TYPE **ENTIRE FORM**

Request Date: _____

Recipient Information

Record Patient's **Complete** Legal Name

_____ ☐ Male ☐ Female

(Last) (First) (Middle)

Birth Date: _____/_____/_____ ABO Group/Rh Type: _____

Patient Medical Record Number (MRN): _____

Diagnosis: _____

Product Requested (Must be completed)

☐ HLA Matched Platelets (MPT) ☐ HPA-_____

☐ Do **NOT** Irradiate (If you do not want Versiti to irradiate HLA/HPA products, check this box.)

Special Product Needs (Must be completed)

CMV-Negative:	Rh-Pos for Rh-Neg Acceptable
☐ Yes ☐ No ☐ Preferred	☐ Yes ☐ No ☐ N/A

Comments (eg. How many, When needed?)

Order Shipment Information

Ordering Physician: _____

Hospital/Bill to: _____

Ship to: _____

Address:_____ City:_____ State:_____ Zip:_____

Contact Information

Completed by: _____ 24 Hr. Blood Bank Phone: _____

Ordering Information

*** Attach Histocompatibility Report, if available.**

All orders MUST be called to 414-937-6101. Please fax the completed form to 414-933-6833, attention "Special Patient Services", no later than the next business day following the verbal request. This form can also be scanned to SPSMatchedPlatelets@bcw.edu.

Special Product Request Form Instructions

Requesting Facility

The following fields are completed by the requesting facility. The form must be completed and faxed to Special Patient Services no later than the next business day following the verbal request.

Demographic information must include at a minimum, of the following:

- Recipient's **complete** legal name (no nicknames or short names)
- Date of birth
- Male/Female

Demographic information must be a computer generated label, face sheet or addressographed label. Demographic information should be supplied by the facility or physician responsible for providing the treatment of the patient. Demographic information generated from handheld label makers or word processing programs are not considered acceptable.

Field Name	Action
Request Date	Record current date.
Demographic Information	Apply the recipient's demographic information label in the area provided, **OR** attach a demographic information sheet to the form. The information must contain the recipient's **complete** legal name, date of birth, and gender.
Recipient Information	
Patient's Legal Name	Record the recipient's legal last name, first name, and middle name.
☐ Male ☐ Female	Indicate the recipient's gender.
Birth Date	Record date of birth: month/date/year.
ABO Blood Group/Rh Type	Record recipient's ABO blood group and Rh type.
Patient MRN #:	Record the Recipient's Patient ID number or Medical Record Number.
Diagnosis	Record the patient diagnosis.
Product Information	
Product Requested	Indicate the product being requested.
Special Product Needs	
CMV-Negative:	Indicate choice.
Rh-Pos for Rh-Neg Acceptable	
Red Cell Antibody	
Comments	Record additional comments regarding special product needs.
Order Shipment Information	
Ordering Physician	Record the name of the ordering physician.
Hospital/Bill to	Record the name of Hospital/Bill to.
Ship to	Record where the product is to be shipped and the 24 hour phone number of the facility.
Address, City, State, Zip	Record the Address, City, State, Zip code of the facility that the product is to be shipped to.
Contact Information	
Completed by / 24 Hr. Blood Bank Phone	Record your name as the contact person and phone number at the ordering hospital blood bank.

Additional forms may be obtained by visiting the Versiti website at:

www.versiti.org **→ Medical Professionals → Specialty Products & Services → Wisconsin → HLA/HPA Matched Platelets → Special Product Request Form**

If you are unable to obtain a form online, contact Special Patient Services at (414) 937-6101 and a form will be faxed to you.