SPECIAL COMPONENT REQUEST FORM
(Not intended for routine inventory orders)

Hospital requesting product: ____________  Tech: ____________  BCNW Tech Notified: ____________

Date/Time Ordered: ____________  Date/Time to be transfused: ____________

Patient Name (Optional): ____________  Estimated Arrival Date/Time: ____________

Send via: □ AWH Courier  □ Badger Transportation  □ Other: ____________

☐ Leukoreduced RBCs

Number needed: ____________  Patient ABO/Rh type: ____________

Special Requirements (check all that apply):

☐ Irradiated  ☐ Other: ____________

☐ CMV seronegative

☐ Leukoreduced Apheresis Platelets

Number needed: ____________  Patient ABO/Rh type: ____________

Special Requirements (check all that apply):

☐ Irradiated  ☐ ABO type specific

☐ CMV seronegative  ☐ Other: ____________

Comments: ____________________________________________________________________

Please contact BCNW staff by phone (715) 842-0761 to submit order. Please then fax order to one of the following per verbal instructions:

BCNW fax: (715) 845-6429  Aspirus Reference Lab fax: (715) 847-2930

Fax Received: ____________  Date/Time/Tech ____________

Document Control Number: REQ.f1.v3  Date Effective: August 14, 2014