

EMERGENCY RELEASE FORM

PATIENT LABEL

TO BE COMPLETED BY ORDERING PHYSICIAN

I believe this patient's life will be in jeopardy without an emergency transfusion due to the following:

Trauma Chronic Blood Loss Other/explain: _____

I understand that all required compatibility testing has not been completed. Blood Bank personnel will perform routine compatibility testing as soon as possible and they will report any evidence of incompatibility to me. Therefore, with full knowledge of the risks, I accept the responsibility and release the Medical Director and personnel of the McLaren Central Michigan blood bank of the responsibility for adverse reactions resulting from this transfusion.

Physician Signature or R.N. Signature _____
For (Print Physician Name)

TO BE COMPLETED BY BLOOD BANK

Based on the physician requested emergency transfusion I have issued the following in accordance with Blood Bank policy, prior to the completion of required compatibility testing:

Unit # Product Code Expiration Type

Check one:

- Uncrossmatched, O Negative packed red blood cells**
- Immediate spin crossmatch compatible, type specific packed red blood cells**
- Uncrossmatched, O Positive packed red blood cells**
- Other:** _____

Check if applicable:

- History of clinically significant antibody/antibody screen positive; increased risk of incompatibility**
- No history available**

Comment: _____

For patient:

Last Name First Name MR # Dept

BB Bracelet # DOB Sex Blood Type

Blood Bank Tech Signature Date



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