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| ICD 9 Code/Diagnosis: |
| Requesting Physician/PI.#: |
| Physician's Pager #: |

Packed Cells (Adult Peds) Plateletpheresis Autologous
Fresh Frozen Plasma (Jumbo Adult Peds) Other

TRANSFUSION SERVICE STAFF:

Blood Component Donor # _____ inspected for color, appearance, expiration date, clots, and hemolysis by: _____

Identifications verified by: _____

NURSING STAFF: PLEASE CALL 4-2870 TO REQUEST BLOOD DELIVERY.

Receiving RN (Signature) _____ verified the recipient is:

| | |
|----------------------|--|
| AFFIX LABEL OR PRINT | |
| Name: | |
| MR#: | |

Medical Necessity: Medicare and Medi-Cal will pay only for tests that meet the Medicare and Medi-Cal coverage criteria and are reasonable and necessary to treat or diagnose an individual patient.

UC DAVIS MEDICAL CENTER
#71451-605 (7/99)

BLOOD BANK ORDER FORM (B605)

Ralph Green, M.D., DIRECTOR