CLAY COUNTY HOSPITAL
Your #1 Choice in Healthcare
911 Stacy Burk Dr. Flora, IL 62839 Phone: 618-662-2131

Emergency Transfusion Release Form

PATIENT NAME: _____ DOB: _____ LOCATION: _____

PROVIDER: _____ PATIENT ID NUMBER: _____

I CERTIFY THAT THIS PATIENT NEEDS IMMEDIATE BLOOD TRANSFUSION AS A LIFE SAVING MEASURE AND ORDER THE BLOOD BANK TO FOLLOW PROCEDURE AS INDICATED BELOW:

- 1. If time does not permit to type the patient's blood prior, release Group O Rh Negative packed cells, uncross-matched.
- 2. If time permits to type the patient's blood, release the patient's group and Rh type specific blood, uncross-matched.

I release Clay County Hospital, the Laboratory Director of Clay County Hospital, and its Laboratory personnel from the responsibility of this decision.

Provider Signature: _____ Date/Time: _____

Printed Provider Name: _____

NOTICE TO ATTENDING PROVIDER

Clay County Hospital, the Laboratory Director, and other personnel cannot assume the medical or legal responsibility for compatibility of blood, which has not been properly cross-matched because of this order. (American Association of Blood Banks)

1. Please select the procedure above you would like the Blood Bank to follow.
2. Sign this order.

Unit Donor #	Unit Exp. Date:	ABO and Rh type	Component	Releasing Technologist