WELLSPAN® HEALTH

☐ Ephrata Community Hospital ☐ The Good Samaritan Hospital of Lebanon
☐ The Gettysburg Hospital ☐ York Hospital

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

BLOOD BANK CONSULT ORDER

Fax this form to blood bank at initial OB intake, and reassess around 28 weeks.
Fax: (717) 812-7881

Date: _____ Age: _____ Grav: _____ Para: _____

Father of Baby: _____ EDD: _____

Patient Address: _____ Is Preterm Delivery anticipated: _____

Provider/Group: _____ Office Phone: _____ If yes, EDD: _____

PREGNANCY BLEEDING RISK CONDITIONS

Needs Blood Bank Work-Up (T & C):
- ☐ Maternal blood antibodies
- ☐ Declines transfusion
- ☐ Dysfibrinogenemia
- ☐ Hemophilia A
- ☐ Hemophilia B
- ☐ Von Willebrand disease
- ☐ Bleeding problems
- ☐ Sickle cell anemia
- ☐ Hemolytic disease of newborn
- ☐ Fetal anemia
- ☐ Neonatal alloimmune thrombocytopenia
- ☐ HELLP, current pregnancy

High Risk: (T & C):
- ☐ Platelets < 100
- ☐ Placenta previa
- ☐ Severe anemia (< 8.0)
- ☐ Suspected Placenta percreta or accreta
- ☐ History post-partum hemorrhage

Moderate Risk: (T & S):
- ☐ BMI > 40
- ☐ Maternal age < 18
- ☐ Maternal age > 40
- ☐ Multiple gestation
- ☐ > 4 prior vaginal deliveries
- ☐ Prior CD or Uterine surgery
- ☐ Large uterine fibroids
- ☐ Fetal weight > 4kg
- ☐ Anti-coagulant therapy

Notes:

ORDERING PROVIDER	PRINTED NAME	DATE	TIME

For Blood Bank Only:

Factor / Product needed: Dose:

Hematologist:

Notes:

SIGNATURE	PRINTED NAME	DATE	TIME

PLEASE CALL BLOOD BANK WITH ANY QUESTIONS AT (717) 851-2510

Form #10429 Rev. (05/17)

WBBX0001