CONVALESCENT PLASMA ORDER FORM

Fax this request to (816) 531-7843 call when faxing

24 Hour phone (816) 968-4015

Facility Information *Do Not Abbreviate*

Facility Name____

Address 1____

Address 2____

City/State/Zip____

Phone Number____

Alternate Phone Number____

eMail____

Note: The facility listed above is where the blood product will be shipped.

Product Requested

ABO type______________________________

Quantity_______________________________

Can you confirm that your facility as registered through Mayo Clinic eIND or the FDA and the patient is approved? Yes No

Facility eIND Number, if available ____

Unique Patient Code or eIND ____

Person Placing Order (print) ___________________________ Date _________________Time ___________

Convalescent plasma will be delivered as soon as possible. This may be a longer wait than typical blood products due to unique donor availability.

CBC Use Only

Facility entered in BloodHub and EDD _____________________________________

BloodHub Order Number ____

Shipment Notification Sent to facility: Initials ___________Date_____________