LABORATORY ALLIANCE
of Central New York, LLC

Transfusion History Form

Instructions: Patients please complete lines 1 through 8.

Patient Information

1. Patient Name (Print Legibly): _____ _____
   Last First

2. Date of Birth: _____ Sex: **Male / Female** (circle one)

3. Have you been admitted to a hospital in the last 3 months? **No / Yes** (circle one)

   If yes, _____ _____ _____
   Hospital Name City & State Date of Admission

4. Have you ever received a blood product (transfusion)? **No / Yes / Not Sure** (circle one)

5. **If yes**, was it within the last 3 months? **No / Yes / Not Sure** (circle one)

   Where? _____ _____ _____
   Hospital Name City & State Date of Transfusion

6. Have you ever had a stem cell or bone marrow transplant? **No / Yes** (circle one)

   If yes, where? _____ _____ _____
   Hospital Name City & State Date of Transplant

7. Are you scheduled to have surgery? **No / Yes** (circle one)

   If yes, _____ _____ _____
   Hospital Name City & State Date of Surgery

8. **Females Only:** Are you pregnant now or have you been pregnant within the last **6** months?
   No / Yes / Not Sure (circle one) _____
   Due date if applicable

   If yes, Did you receive an Rh Immune Globulin (RhoGam, MICRhoGam, Rhophylac) shot within the last **6** months?
   No / Yes / Not Sure (circle one)

   If yes, date of last dose _____

For Lab / Collection Staff Use Only

Draw Station Location: _____
Today's Date: _____

For Blood Bank Staff Use Only

Blood Bank Dept. Phone Numbers:

- Crouse: 315-470-7404