COVID-19 Convalescent Plasma (CCP) Order Form

Date Faxed: _____

Faxed By: _____

Section 1: Ordering Hospital/Blood Center	
Hospital Name	
Requesting Blood Center (if applicable)	
Contact for this Order	
Phone Number	
Email	

Section 2: Order Details	
Number of Units (~200-300 ml)	☐ 1 ☐ 2 ☐ Other _____
ABO Requested	☐ O ☐ A ☐ B ☐ AB
Other Order Information	

Section 3: Shipment Information	
Delivery Address	
Delivery Information	☐ STAT – Delivery within approximately 8 hours ☐ ROUTINE – Delivery within approximately 24 hours
Delivery Method	Please indicate preferred method of shipment ☐ Ship by air ☐ Ship by MNX or CrossRoads | Account Number: _____ ☐ Ship by Fed Ex | Account Number: _____

COMMENTS:	