STANFORD BLOOD CENTER

Phone (650) 725-2491
Fax (650) 724-5304

3373 Hillview Avenue
Palo Alto, CA 94304-1204

COVID-19 Convalescent Plasma (CCP) Order Form

Date Faxed: _____

Faxed By: _____

Section 1: Ordering Hospital/Blood Center	
Hospital Name	
Requesting Blood Center (if applicable)	
Is this order for a specific patient	☐ YES ☐ NO If YES complete section 2. If NO, go to section 3
Contact for this Order	
Phone Number	
Email	

Section 2: Patient Information			
Name			
MRN		Date of Birth	
ABO Type	☐ O ☐ A ☐ B ☐ AB		
IND information for patient's transfusion	☐ Expanded Access Protocol (Mayo IND) ☐ Emergency IND from FDA ☐ Clinical Trial IND	IND # (if available)	
Ordering Provider		Contact	

Section 3: Order Details	
Number of Units (~200-300 ml)	☐ 1 ☐ 2 ☐ Other _____
ABO Requested	☐ O ☐ A ☐ B ☐ AB
Other Order Information	

Section 4: 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 Cross Roads | Account Number: _____ ☐ Ship by Fed Ex | Account Number: _____

COMMENTS:	

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