BLOOD TRANSFUSION SERVICE REQUEST FORM (2018)

Provincial Clinical Laboratory

Queen Elizabeth Hospital
Charlottetown, PEI
Phone (902) 894-2300
Fax (902) 894-2415

Prince County Hospital
Summerside, PEI
Phone (902) 438-4280
Fax (902) 438-4281

Address for Non-PEI Residents Required

Name: _____

Street: _____ Place Label Here

City: _____ Prov./State _____

Postal Code/Zip: _____

Payment Responsibility ☐ WCB ☐ DVA ☐ DND ☐ RCMP ☐ Self Pay Canadian ☐ Self Pay Non-Canadian Provincial Medicare # exp date:	Facility and Unit	DOB: MMM-DD-YYYY	Sex	Medical Record Number (MRN)
Date Required: MMM/DD/YYYY	Time Required:	Ordering Provider: Full Name		
Is Patient IgA Deficient: ☐ Yes	Previous Transfusion Reaction: Specify		Known Antibodies: Specify	

COLLECTION PROTOCOL

Date and time of collection as well as the phlebotomist's signature MUST be recorded on BOTH the specimen label AND the requisition in accordance with Canadian Standards Association requirements. Specimen labels and requisitions failing to meet this protocol will not be accepted for testing. The preferred specimen type for transfusion tests is a 6 mL K2 EDTA (Purple Top) tube.

I certify that I have verified that the name and identification number on this requisition and the blood specimen label are the same as those of the patient's.

_____ **Date:** MMM/DD/YYYY **Time:** _____

Sample Drawn By: Signature (First Initial - Complete Last Name)

The following are required questions for Group & Screen, Preadmission, or Crossmatch

Has the patient been transfused in the last 3 months?	**Has the patient been pregnant in the last 3 months?**
☐ Yes ☐ No	☐ Yes ☐ No
If yes, specify when and where: _____	**If yes, what is the due date (EDC) :** MMM/DD/YYYY

TEST REQUESTS

☐ **Group & Screen**

☐ **Preadmission** Surgery date: MMM/DD/YYYY

☐ **Crossmatch** Number **Units**

Special RBC requirements: Specify

Transfusing facility : _____

Indications (Required)

- ☐ Hgb < 70 g/L
- ☐ Hgb 70 - 80 g/L with cardiovascular disease or impaired tissue oxygenation
- ☐ Preoperative
- ☐ Major bleeding
- ☐ Other: Specify

☐ **Prenatal** Due date/EDC: MMM/DD/YYYY Date of last RhIg injection: MMM/DD/YYYY

☐ **Blood Group Determination**

☐ **Cord Blood** **Note:** must label specimen and requisition with both mother AND baby labels

☐ **Direct Antiglobulin Test (Direct Coombs)**

☐ **Other:**

SEE REVERSE FOR PRODUCT ORDERS

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PRODUCT ORDERS

For help with transfusion thresholds, please refer to:
http://transfusionontario.org/en/wp-content/uploads/sites/4/2016/03/Clinincal-Practice-Recommendations-for-Blood-Component-use-in-Adult-Inpatients.pdf

RBCs see Crossmatch order on reverse

☐ **Platelets** (1 dose = 1 bag) Number _____ doses

Patient's platelet count: Number _____ x10^9/L

Special requirements: Specify

Indications

- ☐ Platelets <10
- ☐ Platelets <20 (adult minor procedure)
- ☐ Platelets <50 (adult major procedure)
- ☐ Platelets <100 (adult head trauma or neurosurgery)
- ☐ Platelet dysfunction or marked bleeding
- ☐ Other: Specify

☐ **Plasma** Dosing: 10-15 mL/kg for adults

1 unit = approx. 250 mL Number _____ units

Indications

- ☐ Bleeding or Pre-op patient with PTT or INR >1.5x normal
- ☐ Massive bleed with PTT and INR not available
- ☐ Other: Specify

☐ **Fibrinogen Concentrate**

	Patient Fibrinogen Level	Dose (adult)
☐	0.5 – 1.0 g/L	2 g
☐	< 0.5 g/L	4 g

☐ **IVIG** Number _____ g **Note:** patient must have a current IVIG request form signed by physician

☐ **Rh Immune Globulin**

- ☐ 300 µg
- ☐ Specify µg

☐ **Albumin**

- ☐ 5% (250 mL vial)
- ☐ 25% (100 mL vial)

Number _____ vials

☐ **Octaplex/ Beriplex**

Indications

Patient is on warfarin or is vitamin K deficient and:

- ☐ Has major bleeding
- ☐ Requires an urgent surgical procedure (i.e. must be performed within next 6 hours)

	INR	Dose (adult)
☐	1.7 to 5.0	40 mL (1000 IU) **and 10mg Vitamin K** (IV)
☐	≥ 5.1	80 mL (2000 IU) **and 10mg Vitamin K** (IV)
☐	Unknown, with major bleeding	
☐	Intracranial hemorrhage	

☐ **Other:**

SEE REVERSE FOR TEST ORDERS