

TML BLOOD COMPONENT AND PRODUCT PICKUP SLIP

Last Name:

First Name:

HSN #:

Contact information for tube transport:

Name (print): Phone: Unit:

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First Name:

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Contact information for tube transport:

Name (print): Phone: Unit:

Component or Product Requested	Amount/Volume/Dose	Component or Product Requested	Amount/Volume/Dose
<input type="checkbox"/> Red Blood Cells	unit(s)	<input type="checkbox"/> Red Blood Cells	unit(s)
<input type="checkbox"/> Platelets	dose(s)	<input type="checkbox"/> Platelets	dose(s)
<input type="checkbox"/> Plasma	unit(s)	<input type="checkbox"/> Plasma	unit(s)
<input type="checkbox"/> Cryoprecipitate	unit(s)	<input type="checkbox"/> Cryoprecipitate	unit(s)
<input type="checkbox"/> Win Rho: <input type="checkbox"/> 120 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> Other	mcg	<input type="checkbox"/> Win Rho: <input type="checkbox"/> 120 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> Other	mcg
<input type="checkbox"/> Albumin: <input type="checkbox"/> 5% <input type="checkbox"/> 25%	mL	<input type="checkbox"/> Albumin: <input type="checkbox"/> 5% <input type="checkbox"/> 25%	mL
<input type="checkbox"/> IVIG	g	<input type="checkbox"/> IVIG	g
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

Porter: Print First Initial & Last Name:

Form #102930 (Saskatoon Area) 11/2018 Category: Requisitions

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