

TML BLOOD COMPONENT AND PRODUCT PICKUP SLIP

Last Name:

First Name:

HSN #:

Contact information for tube transport:

Name (print first & last name):

Phone #: Tube Station #:

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

Porter: Print First Initial & Last Name:

Form #102930 (Saskatoon Area) 11/2019 Category: Requisitions

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