PATIENT IDENTIFICATION

Former Saskatoon Health Region
Transfusion Medicine Service
Phone: RUH – 306-655-2179 SCH – 306-655-8204 SPH – 306-655-5168
Phone: Humboldt – 306-682-8128

FIRST NAME: _____

LAST NAME: _____

HSN: _____

D.O.B.: _____

BLOOD AND TISSUE PRODUCT REQUEST

All unshaded sections MUST be completed.

Ordering Site

Transfusion Site: ❑ RUH ❑ JPCH ❑ SCH ❑ SPH ❑ Humboldt ❑ Cancer Centre ❑ Rural/Other:	Unit (inpatient):	Phone #:
Ordering Physician:	Date & Time Required:	

PRODUCT REQUESTED

❑ Red Blood Cells

Clinical reason for transfusion: _____
Most recent hemoglobin: _____ g/L
Patient actively bleeding: ❑ Yes ❑ No
Cardiac disease: ❑ Yes ❑ No
Signs/Symptoms of impaired tissue oxygenation: ❑ Yes ❑ No
(presyncope, hypotension, tachycardia, chest pain, EKG changes, dyspnea, etc. **NOT** fatigue alone).

Adults – # of Units: _____
Pediatric/Neonate transfusion: _____ mL required

❑ To be transfused: ❑ ASAP ❑ Required at _____ hours
❑ On Hold
❑ For surgery (Date of surgery):_____

Special Requirements (see over for eligibility)
Indication for special requirement: _____
❑ Irradiated ❑ Washed ❑ Other (Specify):

❑ Plasma

Diagnosis _____
Adults – # of Units:_____
Pediatric/Neonate transfusion: _____ mL required

❑ To be transfused: ❑ ASAP ❑ Required at _____ hours
❑ For surgery (Date of Surgery):_____

❑ Cryoprecipitate

Indication _____
# of Units: _____

Note: The standard dose is 1 unit/10 kg

❑ Cryosupernatant Plasma

Note: This product is for plasma exchange (PLEX) use only

# of Units: _____

Date & Time required: _____

❑ Uncrossmatched Red Blood Cells

of Units _____ (for situations of emergency transfusion only)

To obtain uncrossmatched blood from Transfusion Medicine, a patient identification MUST be provided. Standards require that the need for transfusion of uncrossmatched blood is documented and signed by the physician/MRP in the patient's chart.

❑ Plasma – Solvent Detergent

Request MUST be approved by the Transfusion Medical Physician

Adults – # of Units:_____
Pediatric/Neonate transfusion: _____ mL required

❑ To be transfused: ❑ ASAP ❑ Required at _____ hours

❑ Platelets

Indication _____
Adult doses (number required): _____
Pediatric/Neonate transfusion: _____ mL required

Note: An adult platelet dose is equivalent to:
1 apheresis (single donor) platelet or 4 pooled Buffy-coat platelets

❑ To be transfused: ❑ ASAP ❑ Required at _____ hours
❑ On Hold
❑ For surgery (Date of Surgery):_____

Special Requirements (see over for eligibility)
Indication for special requirement: _____
❑ Irradiated ❑ Other (Specify):

❑ Tissue Product

Date Required: _____

❑ Femoral Head: grams required _____

❑ Corticocancellous Chips:
- ❑ Small (less than 15 g)
- ❑ Medium (15-35 g)
- ❑ Large (greater than 35 g)

❑ Amniotic Membrane:
- ❑ Half ❑ Whole ❑ Extra Large

❑ Other (Specify type and size below)

❑ Cellular Therapy Product

❑ Hematopoietic Progenitor Cells – Autologous
❑ Hematopoietic Progenitor Cells – Allogeneic
Volume to transfuse:
- ❑ All product
- ❑ Portion of the product (specify amount): _____

❑ DLI – Specify amount: _____

Lab Use Only – Documentation of Communication

Date:	Time:	Ward/Site:	Ward staff/X-trainer contacted:	Tech:
❑ Product ready/Tags printed ❑ Product delay ❑ Other:				

Special Requirement	Eligible Patients

Irradiated Cellular Blood Components	• Low birth weight premature newborns (less than1200 g) until 4 months of age
	• History of intrauterine transfusion, until 6 months after the initial expected delivery date (40 weeks gestational age)
	• Neonatal exchange transfusion
	• Directed donations
	• HLA matched components
	• Allogenic stem cell/bone marrow transplant recipients (from start of conditioning chemotherapy, for life after transplant)
	• Autologous stem cell/bone marrow transplant recipients (from 7 days before the start of stem cell mobilization, until 6 months post-transplant)
	• Allogeneic stem cell donors (7 days prior to collection and during the collection process only)
	• Congenital T-cell immune deficiency (DiGeorge syndrome, SCID)
	• Hodgkin's Lymphoma, for life
	• Patients receiving or who have received the following (for life, from the time of drug initiation):
	  • Anti-thymocyte globulin (ATG; Thymoglobulin, Atgam)
	  • If given for severe aplastic anemia or conditioning prior to allogenic bone marrow transplant
	  • Alemtuzumab (Campath)
	  • Bendamustine (Treakisym, Ribomustin, Levact and Treanda)
	  • Cladribine/2-CDA (Leustatin)
	  • Clofarabine (Clolar)
	  • Deoxycoformicin (Pentostatin)
	  • Fludarabine (Fludara)

CMV Negative Cellular Blood Components	• Intrauterine transfusion (not available in Saskatchewan) *All cellular blood components in Canada have undergone pre-storage leukoreduction and are considered "CMV safe". Transfusion of leukoreduced plus CMV seronegative blood components has not been identified to provide additional protection against transfusion-transmitted CMV.*
Apheresis platelets	• Aplastic anemia • Congenital marrow failure disorders (Diamond Blackfan anemia, Fanconi anemia) • Pediatric patients requiring less than 200 mL • Neonates (less than 4 mo old) • Patients meeting requirements for HLA or HPA Matched platelets (see below)
HLA Matched Apheresis Platelets	• Patients with HLA antibodies and demonstrated platelet refractoriness
HPA Matched Apheresis Platelets	• Patients with HPA1a (PLA1) antibodies • Neonates with Neonatal Alloimmune Thrombocytopenia (NAIT) • Patients with history of Post Transfusion Purpura (PTP)
Phenotype Matched Red Blood Cells for Rh and Kell (prophylactic antigen matching)	• Aplastic anemia, pure red cell aplasia • Congenital marrow failure disorders (Diamond Blackfan anemia, Fanconi anemia) • Sickle cell anemia • Thalassemia
Washed Red Blood Cells	• Neonates with high potassium levels and/or requiring large volumes transfusion • Patients who experience recurrent, severe allergic reactions • IgA deficient patients with anti-IgA antibodies or history of severe reaction to transfusions • Patients with a history of PTP, if HPA-matched donor red blood cells are unavailable