**BLOOD AND TISSUE PRODUCT REQUEST**

All unshaded sections MUST be completed.

### Ordering Site

<table>
<thead>
<tr>
<th>Transfusion Site</th>
<th>RUH</th>
<th>JPC</th>
<th>SCH</th>
<th>SPH</th>
<th>Humboldt</th>
<th>Cancer Centre</th>
<th>Rural/Other</th>
<th>Unit (inpatient)</th>
<th>Phone #</th>
</tr>
</thead>
</table>

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

- 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): ________________

#### 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.

#### 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): ________________

#### 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: ________________

#### Plasma

- Diagnosis ________________
- Adults – # of Units: ________________
- Pediatric/Neonate transfusion: ________________ mL required
- To be transfused: ASAP  Required at _______ hours
- For surgery (Date of Surgery): ________________

#### Cryoprecipitate

- Indication ________________

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: ________________

#### 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

#### 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): ________________

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**Lab Use Only – Documentation of Communication**

Date: ________________

Time: ________________

Ward/Site: ________________

Ward staff/X-trainer contacted: ________________

Tech: ________________

- Product ready/Tags printed
- Product delay
- Other: ________________

Form #103220  (Saskatoon Area)  10/2019  Category: Requisitions
<table>
<thead>
<tr>
<th>Special Requirement</th>
<th>Eligible Patients</th>
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<td><strong>Eligible Patients</strong></td>
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| **Irradiated Cellular Blood Components**                 | • Low birth weight premature newborns (less than 1200 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**    | • 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 |