

FIRST NAME: _____

LAST NAME: _____

HSN: _____

D.O.B.: _____

BLOOD AND TISSUE PRODUCT REQUEST FORM

All unshaded sections **MUST** be completed.

ORDERING SITE		
Transfusion Site: <input type="checkbox"/> RUH <input type="checkbox"/> SCH <input type="checkbox"/> SPH <input type="checkbox"/> Humboldt <input type="checkbox"/> Cancer Centre <input type="checkbox"/> Rural/Other:	Ward: (in-patient)	Phone #:
Ordering Physician:	Date & Time Required:	

PRODUCT REQUESTED	
<input type="checkbox"/> 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 the need for transfusion of uncrossmatched blood is documented and signed by the physician/MRP in the patient's chart. <input type="checkbox"/> Red Blood Cells: Indication _____ Adults: # of Units: _____ Pediatric/Neonate transfusion: _____ mL required <input type="checkbox"/> To be transfused: <input type="checkbox"/> ASAP <input type="checkbox"/> Required at _____ hours <input type="checkbox"/> On Hold <input type="checkbox"/> For surgery (Date of Surgery): _____ <input type="checkbox"/> Autologous or Directed Donation Special Requirements (see over for eligibility) Indication for special requirement: _____ <input type="checkbox"/> Irradiated <input type="checkbox"/> Washed <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Cryoprecipitate: Indication _____ # of Units: _____ Note: The standard dose is 1 unit/10 kg <input type="checkbox"/> Cryosupernatant Plasma Note: This product is for plasma exchange (PLEX) use only # of Units: _____ Date & Time Required: _____ <input type="checkbox"/> Cellular Therapy Product <input type="checkbox"/> Hematopoietic Progenitor Cells – Autologous <input type="checkbox"/> Hematopoietic Progenitor Cells – Allogeneic Volume to transfuse: <input type="checkbox"/> All product <input type="checkbox"/> Portion of the product (specify amount: _____) <input type="checkbox"/> DLI: Specify amount: _____
<input type="checkbox"/> 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 <input type="checkbox"/> To be transfused: <input type="checkbox"/> ASAP <input type="checkbox"/> Required at _____ hours <input type="checkbox"/> On Hold <input type="checkbox"/> For surgery (Date of Surgery): _____ Special Requirements (see over for eligibility) Indication for special requirement: _____ <input type="checkbox"/> Irradiated <input type="checkbox"/> Other (Please specify): _____	<input type="checkbox"/> Tissue Product Date Required: _____ <input type="checkbox"/> Femoral Head: # Required _____ <input type="checkbox"/> Quarter <input type="checkbox"/> Half <input type="checkbox"/> Whole: <input type="checkbox"/> Small (<100 g) <input type="checkbox"/> Medium (100-120 g) <input type="checkbox"/> Large (>120 g) <input type="checkbox"/> Corticocancellous Chips: <input type="checkbox"/> Small (<15 g) <input type="checkbox"/> Medium (15-35 g) <input type="checkbox"/> Large (>35 g) <input type="checkbox"/> Amniotic Membrane: <input type="checkbox"/> Half <input type="checkbox"/> Whole <input type="checkbox"/> Extra Large <input type="checkbox"/> Other (Specify Type and Size Below):
<input type="checkbox"/> Plasma: Diagnosis _____ Adults: # of Units: _____ Pediatric/Neonate transfusion: _____ mL required <input type="checkbox"/> To be transfused: <input type="checkbox"/> ASAP <input type="checkbox"/> Required at _____ hours <input type="checkbox"/> For surgery (Date of Surgery): _____	
<input type="checkbox"/> Plasma – Solvent Detergent Requests MUST be approved by the Transfusion Medicine Physician. Adults: # of Units: _____ Pediatric/Neonate transfusion: _____ mL required <input type="checkbox"/> To be transfused: <input type="checkbox"/> ASAP <input type="checkbox"/> Required at _____ hours	

Lab Use Only – Documentation of Communication				
Date:	Time:	Ward/Site:	Ward staff/X-trainer Contacted:	Tech:
<input type="checkbox"/> Product Ready/Tags Printed <input type="checkbox"/> Product Delay <input type="checkbox"/> Other:				

BLOOD AND TISSUE PRODUCT REQUEST FORM

Special Requirement	Eligible Patients
Irradiated Cellular Blood Components	<ul style="list-style-type: none"> • 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): <ul style="list-style-type: none"> • Anti-thymocyte globulin (ATG) <ul style="list-style-type: none"> • If given for severe aplastic anemia or conditioning prior to allogeneic 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	<ul style="list-style-type: none"> • Intrauterine transfusion (not available in Saskatchewan) <p><i>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.</i></p>
Apheresis Platelets	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Patients with HLA antibodies and demonstrated platelet refractoriness
HPA Matched Apheresis Platelets	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Aplastic anemia, pure red cell aplasia • Congenital marrow failure disorders (Diamond Blackfan anemia, Fanconi anemia) • Sickle cell anemia • Thalassemia
Washed Red Blood Cells	<ul style="list-style-type: none"> • 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