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.: _____

PLASMA PROTEIN PRODUCT REQUEST

All unshaded sections MUST be completed.

Ordering Site

Requesting Site: ❑ RUH ❑ SCH ❑ SPH ❑ Rural _____ ❑ Other (Specify):

Unit:	Phone #:	Date & Time Required:
Requesting MRHP:		Product Indication:

PRODUCT REQUESTED

Note: Orders will be filled for a 24 hour period only

Note: Saskatchewan Bleeding Disorders Program patients will have a **Factor First card** indicating the product name and dose

Albumin 5% (5 gm/100 mL)
❑ 50 mL ❑ 250 mL ❑ 500 mL
Indicate total # of vials required: _____

Albumin 25% (25 gm/100 mL)
❑ 50 mL ❑ 100 mL
Indicate total # of vials required: _____

Anti-Inhibitor Coagulant Complex (FEIBA)
❑ Dosage Requested: _____ IU

C1 Esterase Inhibitor
❑ Product Name: _____
Dosage Requested: _____ IU

Cytomegalovirus Immune Globulin (Cytogam)
❑ 2.5 gm Indicate total # of vials required: _____

Factor VIII Concentrate
❑ Product Name:_____
Dosage Requested: _____ IU

Factor IX Concentrate
❑ Product Name:_____
Dosage Requested: _____ IU

Fibrin Sealant
❑ 1 mL Evicel ❑ 2 mL Evicel ❑ 5 mL Evicel
❑ 4 mL Tisseel ❑ 2 mL Tisseel (Tisseel for limited indications)

Fibrinogen Concentrate (RiaSTAP)
❑ 1 gm Indicate total # of vials required: _____

von Willebrand Factor/Factor VIII Concentrate
❑ Product Name:_____
Dosage Requested: _____ IU

Other Plasma Protein Product
(Some products may require Canadian Blood Agency approval and Emergency Drug Release)
❑ Specify Product: _____
Dosage Requested: _____

Hepatitis B Vaccine
❑ 0.5 mL (pediatric dose)
❑ 1 mL

Hepatitis B Immune Globulin
Dosage Requested: _____ mL
Patient Weight: _____ kg
Recipient's home phone number: _____
Reason for use: _____
Mother's name (for neonatal recipients only): _____

IV Immune Globulin (Dose should be based on adjusted body weight)
Dosage Requested: _____ g
Recipient's Diagnosis: _____
Recipient's Weight: _____ kg
Special Requirements – Physician documentation is required:
❑ Gammagard S/D Lyophilized (Powdered)
❑ Other (Specify): _____

Prothrombin Complex Concentrate (Beriplex/Octaplex)
Dosage Requested: _____ IU
Anticoagulation? ❑ No ❑ Yes (Indicate Type)
❑ Warfarin ❑ Factor Xa inhibitor ❑ Other _____
For Warfarin reversal: ensure Vitamin K has been ordered concurrently.
PCC Dose is INR Based → INR 1.5-2.9 = 1000 IU, 3.0-5.0 = 2000 IU, ≥5.1 = 3000 IU

Rabies Vaccine (Medical Health Officer approval required)
❑ 2.5 IU

Rabies Immune Globulin Recipient Weight: _____ kg
Dosage Requested: _____ mL (Product contains 150 IU/mL)
For post-exposure prophylaxis, usual does is 20 IU/kg of body weight)

Rh Immune Globulin (WinRho)
❑ 120 µg ❑ 300 µg
❑ Other (Specify Amount): _____ µg

Tetanus Immune Globulin
❑ 250 Units

Thrombin Sealant
❑ Hemostatic Matrix (Surgiflo) – Indicate # required _____

Varicella Zoster Immune Globulin
❑ 125 IU - Indicate # of vials required: _____

Lab Use Only – Documentation of Communication with Care Provider

Date:	Time:	Unit:	Unit staff/X-trainer Contacted:	Tech:

❑ Product Ready/Tags printed ❑ Product Delay ❑ Other: