Benefits of providing COMPLETE and LEGIBLE information:

- ➢Reduces turn around time when processing patient samples
- ➢Promotes patient safety through reduced transcription errors

PATIENT IDENTIFICATION

Patient Identification MUST include:

- ✓ First and last name
- ✓ HSN or unique identifier
- ✓ Date of Birth

PLASMA PROTEIN PRODUCT REQUEST

All unshaded sections MUST be completed.

Ordering Site section MUST be fully completed

Failure to supply a phone number will lead to delays in contacting the ward on product readiness.

Failure to supply required information will lead to delays in service

Ordering Site

❑ SCH ❑ SPH ❑ Rural _____ ❑ Other (Specify)

#: | Date & Time Required:

Product Indication:

PRODUCT REQUESTED

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

wan Bleeding Disorders Program patients will have a **Factor First card** indicating the pro

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 ❑ Y
❑ Warfarin ❑ Factor Xa inhi
For Warfarin reversal: ensure Vitami K has be
PCC Dose is INR Based → INR 1.5-2 = 1000 IU,

Rabies Vaccine (Med
❑ 2.5 IU

Rabies Immune Globulin
Dosage Requested: _____ m
For post-exposure prophylaxis, usual

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: _____

Fields in the specific product box MUST be completed

Indicate product requested including the amount and volume

IF YOU CHOOSE TO PRINT THIS DOCUMENT, IT IS VALID ONLY ON DAY OF PRINT.

Document #: LSM-482 v #: 6