For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

PHN/PHIN:

Last Name:

First Name:

DOB:

Physician / Authorized Health Care Provider:

Request for Prothrombin Complex Concentrates (PCC)

To request a blood product from facility blood bank:

1. Provide addressograph/label or print request form
2. Provide requesting physician and date required
3. Select (✓) appropriate Indication
4. Fax completed form to blood bank

All PCC orders are considered STAT

Required Information:

Requesting physician:	Date required:
Requesting physician contact number:	Physician specialty:
INR result:	Date and time of INR:
There is an urgent need to reverse: ☐ Warfarin ☐ Direct Oral Anti-coagulants (DOACs)	
Not on Warfarin or DOACs – ***contact Transfusion Medicine physician on-call***	
Patient has/had a history of Heparin-Induced Thrombocytopenia (HIT): ☐ Yes (***contact Transfusion Medicine physician on-call***) ☐ No	

	Indication	Order
1	☐ Congenital Coagulation Factor Deficiency	Consult Bleeding Disorders Clinic: 204-787-2465
2a	☐ Taking warfarin ***and*** actively bleeding or requiring urgent surgery/invasive procedure within 6 hours ***and*** INR is between 1.7 – 3.0	Administer: PCC 1000 IU ***and*** Phytonadione (Vitamin K1) 10 mg IV over 30 min. **Repeat INR 15 min after PCC infusion complete**
2b	☐ Taking warfarin ***and*** actively bleeding or requiring urgent surgery/invasive procedure within 6 hours ***and*** INR is between 3.1 – 5.0	Administer: PCC 2000 IU ***and*** Phytonadione (Vitamin K1) 10 mg IV over 30 min. **Repeat INR 15 min after PCC infusion complete**
2c	☐ Taking warfarin ***and*** actively bleeding or requiring urgent surgery/invasive procedure within 6 hours ***and*** INR is 5.0 or greater	Administer: PCC 3000 IU ***and*** Phytonadione (Vitamin K1) 10 mg IV over 30 min. **Repeat INR 15 min after PCC infusion complete**
2d	Taking warfarin ***and*** (select one indication): ☐ Actively bleeding or requiring urgent surgery/invasive procedure within 6 hours ***and*** INR is unknown ☐ Has an intracranial haemorrhage	Administer: PCC 2000 IU ***and*** Phytonadione (Vitamin K1) 10 mg IV over 30 min. **Repeat INR 15 min after PCC infusion complete**
2e	☐ Taking DOACs and bleeding	Administer: PCC 3000 IU
3	☐ Subsequent dosing (if INR not corrected)	Call Transfusion Medicine physician on-call
4	☐ Cardiac patient in OR	Administer: PCC 1000IU Reassess and re-order if required

As per Manitoba Health, PCC utilization will be audited using the information provided on this form. Incomplete/insufficient information may result in treatment delays. For further information and product infusion information go to Transfusion Manitoba

Transporter Name: _____ **Issued by** *(initials)*: _____ **Date & Time:** _____
(Print)