


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.

 Shared health Soins communs Manitoba	Request for Prothrombin Complex Concentrates (PCC)		Document # F160-INV-16B
			Version # 07
	Approved By: Darcy Heron (approval on file)	Effective Date 14-MAR-2024	Source Document: Shared Health Transfusion Medicine Manual

Request for Prothrombin Complex Concentrates (PCC)

PHN/PHIN:

Last Name:

First Name:

DOB:

Physician /
Authorized Health Care Provider:

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: <input type="checkbox"/> Warfarin <input type="checkbox"/> 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): <input type="checkbox"/> Yes (contact Transfusion Medicine physician on-call) <input type="checkbox"/> No		
	Indication	Order
1	<input type="checkbox"/> Congenital Coagulation Factor Deficiency	Consult Bleeding Disorders Clinic: 204-787-2465
2a	<input type="checkbox"/> 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 K ₁) 10 mg IV over 30 min. Repeat INR 15 min after PCC infusion complete
2b	<input type="checkbox"/> 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 K ₁) 10 mg IV over 30 min. Repeat INR 15 min after PCC infusion complete
2c	<input type="checkbox"/> 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 K ₁) 10 mg IV over 30 min. Repeat INR 15 min after PCC infusion complete
2d	Taking warfarin and (select one indication): <input type="checkbox"/> Actively bleeding or requiring urgent surgery/invasive procedure within 6 hours and INR is unknown <input type="checkbox"/> Has an intracranial haemorrhage	Administer: PCC 2000 IU and Phytonadione (Vitamin K ₁) 10 mg IV over 30 min. Repeat INR 15 min after PCC infusion complete
2e	<input type="checkbox"/> Taking DOACs and bleeding	Administer: PCC 3000 IU
3	<input type="checkbox"/> Subsequent dosing (if INR not corrected)	Call Transfusion Medicine physician on-call
4	<input type="checkbox"/> 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)