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 Release of Blood Components/Product**		**Document #** F160-INV-33
			Version # 03
	Approved By:	**Effective Date**	**Source Document:**
			Shared Health Transfusion Manual

1. Bring **original/copy** of form to blood bank for product pick-up
2. If Transfusion Medicine physician consultation is required, contact HSC Paging 204.787.2071

Ordering Provider Information	**Patient Information**
Name: **Facility/Location**: **Phone** ***(10-digit)*****:** **Fax:** **Clinical Unit/Site for infusion:**	PHN/PHIN Last Name First Name DOB Physician/Authorized Prescriber

Unused blood component/product ***must*** be returned to the blood bank within ***60 minutes*** from time of issue.

TO BE COMPLETED BY CLINICAL UNIT

Date & Time Required:

Clinical Indication:

Home Delivery Instructions:

I. Blood Components

- ☐ Plasma, volume in mL
- ☐ Cryoprecipitate, # of bags
- ☐ Platelets, adult dose
- ☐ Platelets, pediatric dose
- ☐ Special transfusion requirements:

II. Immune Globulin

Ideal body weight calculator *must* be used for patients aged 18 or older to determine dosage https://bestbloodmanitoba.ca/ivig-dose/

Patient: Height: cm | Weight (actual): kg | Date measured:

Sex: ☐ Male ☐ Female

☐ **IVIG*** (preferred product):	☐ **SCIG** (preferred product):
IVIG Dose: g/kg	SCIG Dose: g/kg
Dose for current infusion: *(round down to lowest 5g, e.g. 72g=70g)*	Quantity:

Dosing schema *(e.g. 50g over 2 days repeat every 6 weeks)*:

Prescriber Document must be attached for all ***initial/one-time*** requests and at ***6 months*** for on-going therapy patients

III. Plasma Protein Product

- ☐ Albumin 25%, mLs: ☐ Albumin 5%, mLs:
- ☐ Rh Immune Globulin (RhIg/WinRho): # vials: 300ug (1500IU), # vials: for IU total
- ☐ Other (specify): Quantity:

IV. Prothrombin Complex Concentrate (PCC) requested, complete ***Request for PCC*** form, if applicable

V. Factor Replacement Product: Hematology** consulted? ☐ No ☐ Yes: Physician's name:

Product: Quantity:

Additional Information:

LAB USE ONLY

Issued by (initials): _____ Date: _____ Time: _____ Transporter Name: _____

FOR LAB USE WHEN TRANSPORTED BY PNEUMATIC TUBE SYSTEM Order filled by (Initials): _____

Product	# of units/volume (mL)	Donor Unit/Lot number
❑ Frozen Plasma ❑ Albumin 5% _____ mL ❑ Albumin 25% _____mL ❑ Other:		

FOR *CLINICAL* SITE USE FOR VERIFICATION OR WHEN TRANSPORTED BY PNEUMATIC TUBE *Complete and return to Facility Blood Bank*

Received by: Date: Time:

***Stock IVIG brand will be given unless patient requires a specific brand due to documented adverse reactions**
****Contact Adult or Pediatric Hematologist on-call**