


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

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

Ordering Provider Information	Patient Information
Name: _____	PHN/PHIN _____
Facility/Location: _____	Last Name _____
Phone (10-digit): _____ Fax: _____	First Name _____
	DOB _____
Clinical Unit/Site for infusion: _____	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: _____	Home Delivery Instructions: _____
Clinical Indication: _____	

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

<input type="checkbox"/> IVIG* (preferred product): IVIG Dose: _____ g/kg Dose for current infusion: (round down to lowest 5g, e.g. 72g=70g)	<input type="checkbox"/> SCIG (preferred product): SCIG Dose: _____ g/kg Quantity: _____
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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 (Rhlg/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
<input type="checkbox"/> Frozen Plasma <input type="checkbox"/> Albumin 5% _____ mL <input type="checkbox"/> Albumin 25% _____ mL <input type="checkbox"/> 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