Shared health Soins communs Manitoba	**Request for Release of Blood Components/Product**		**Document #** F160-INV-33
			Version # 02
	Approved By: Dr C Musuka *Approval on file*	**Effective Date** 14-DEC-2020	**Source Document:** Shared Health Transfusion Manual

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

Ordering Provider Information	
Last & Full First Name:	
Location:	
Facility Name:	
Phone # *(10-digit)*:	Fax #:

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

Patient Information *(print or use addressograph)*
Last/First Name: (per Health Card)
Date of Birth (dd/mm/yyyy)
Sex: □ Female □ Male
PHIN: Specify Province or DND if different
MRN:
Encounter #:
Patient Ph #:
Patient Address:

To Be Completed by Clinical Unit

Date & Time Required:

Clinical Indication:

Home Delivery Instructions:

I. Blood Components

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

II. IVIG/SCIG

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):
IVIG Dose: g/kg

☐ SCIG (preferred product):
SCIG Dose: g/kg,
Quantity:

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

Dose for current infusion *(round down to lowest 5g, e.g. 72g=70g)*:

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: for 1500IU, # vials: for IU
☐ Other (specify): Quantity:

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

IV. Factor Replacement Product: Hematology** consulted? ☐ No ☐ Yes: Physician's Name:

Product: Quantity:

Additional Information:

Lab Use Only

Transporter Name: _____ Issued by (Initials): _____

Date: _____ Time: _____

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 SYSTEM
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 adverse reactions
**Contact Adult or Pediatric Hematologist on-call