


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.

 <b>Shared health</b> <b>Soins communs</b> Manitoba	<b>Request for Release of Blood Components/Product</b>		<b>Document #</b> F160-INV-33
			<b>Version #</b> 03
	<b>Approved By:</b>	<b>Effective Date</b>	<b>Source Document:</b>
		Shared Health Transfusion Manual	

1. Bring <b>original/copy</b> of form to blood bank for product pick-up 2. If Transfusion Medicine physician consultation is required, contact HSC Paging 204.787.2071			
<b>Ordering Provider Information</b>		<b>Patient Information</b>	
<b>Name:</b> <b>Facility/Location:</b> <b>Phone (10-digit):</b> <b>Fax:</b> <hr/> <b>Clinical Unit/Site for infusion:</b>		PHN/PHIN Last Name First Name DOB Physician/Authorized Prescriber	
Unused blood component/product <b>must</b> be returned to the blood bank within <b>60 minutes</b> from time of issue.			
<b>TO BE COMPLETED BY CLINICAL UNIT</b>			
<b>Date &amp; Time Required:</b> <b>Clinical Indication:</b>		<b>Home Delivery Instructions:</b>	
<b>I. Blood Components</b> <input type="checkbox"/> Plasma, volume in mL <input type="checkbox"/> Cryoprecipitate, # of bags <input type="checkbox"/> Platelets, adult dose <input type="checkbox"/> Platelets, pediatric dose <input type="checkbox"/> Special transfusion requirements:			
<b>II. Immune Globulin</b> Ideal body weight calculator <b>must</b> be used for patients aged 18 or older to determine dosage <a href="https://bestbloodmanitoba.ca/ivig-dose/">https://bestbloodmanitoba.ca/ivig-dose/</a> <b>Patient:</b> Height:                      cm         Weight (actual):                      kg         Date measured: <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female			
<input type="checkbox"/> <b>IVIG*</b> (preferred product): IVIG Dose:                      g/kg Dose for current infusion: (round down to lowest 5g, e.g. 72g=70g)		<input type="checkbox"/> <b>SCIG</b> (preferred product): SCIG Dose:                      g/kg Quantity:	
Dosing schema (e.g. 50g over 2 days repeat every 6 weeks): <b>Prescriber Document</b> must be attached for all <b>initial/one-time</b> requests and at <b>6 months</b> for on-going therapy patients			
<b>III. Plasma Protein Product</b> <input type="checkbox"/> Albumin 25%, mLs: <input type="checkbox"/> Albumin 5%, mLs: <input type="checkbox"/> Rh Immune Globulin (Rhlg/WinRho): # vials:                      300ug (1500IU), # vials:                      for                      IU total <input type="checkbox"/> Other (specify):                      Quantity:			
<b>IV. Prothrombin Complex Concentrate (PCC)</b> requested, complete <b>Request for PCC</b> form, if applicable			
<b>V. Factor Replacement Product:</b> Hematology** consulted? <input type="checkbox"/> No <input type="checkbox"/> Yes: Physician's name: Product:                      Quantity: Additional Information:			
<b>LAB USE ONLY</b>			
Issued by (initials):                      Date:                      Time:                      Transporter Name:			
<b>FOR LAB USE WHEN TRANSPORTED BY PNEUMATIC TUBE SYSTEM</b> Order filled by (Initials):			
<b>Product</b>		<b># of units/volume (mL)</b>	<b>Donor Unit/Lot number</b>
<input type="checkbox"/> Frozen Plasma <input type="checkbox"/> Albumin 5%                      mL <input type="checkbox"/> Albumin 25%                      mL <input type="checkbox"/> Other:			
<b>FOR CLINICAL SITE USE FOR VERIFICATION OR WHEN TRANSPORTED BY PNEUMATIC TUBE</b> 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