Shared health Soins communs Manitoba	**Request for Release of Red Cells**		**Document #** F160-INV-34
			Version # 03
	Approved By: **Dr. Charles Musuka** **signature on file**	**Effective Date** **17-JUN-2021**	**Source Document:** **Shared Health Transfusion Manual**

Ordering Information: Hospital: _____ Clinical Unit: _____ Ordering Physician: _____ Phone # (*xxx-xxx-xxxx*):_____ **INCOMPLETE FORMS WILL RESULT IN DELAY OR REJECTION OF REQUEST**	PHN/PHIN: Last Name: First Name: DOB: Physician / Authorized Prescriber
Transfusion Criteria for stable non-bleeding inpatients: Hemoglobin is 70g/L or LOWER → Red cells issued Hemoglobin is BETWEEN 71-80 g/L → Order screened Hemoglobin is 81g/L or HIGHER → TM Consult required	Call HSC Paging 204.787.2071 to consult Transfusion Medicine (TM) physician All **unused** red cell units must be returned to the blood bank within **60 minutes** from time of issue.

*For **non-bleeding, hospitalized adult patients**, a single unit transfusion is standard. Additional units will be issued after a repeat hemoglobin and clinical re-assessment has been performed on the patient.*

TO BE COMPLETED BY CLINICAL UNIT

DATE OF TRANSFUSION: ❑ **Today at** _____ | ❑ **Other** (DD/MM/YYYY) : _____ **at** _____

Significant bleeding: ❑ Yes ❑ No

Symptoms: _____

Why is the patient anemic? : _____

Is the patient on chronic transfusion therapy? ❑ Yes, Indication: _____ ❑ No ❑ Unknown

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RED BLOOD CELLS: *one unit will be released at a time unless patient is actively bleeding*

Pre-transfusion Hb: _____ **g/L** **Date/time of testing:** _____

❑ **Uncrossmatched Emergency, # of units:** _____

❑ **Crossmatched, # of units:** _____

❑ **Neonatal patients ONLY indicate volume required**: _____ **mLs**

❑ **Special transfusion requirements** (*e.g. washed, irradiated*): _____

LAB USE ONLY

Issued by (initials): _____ Transporter Name: _____

Date: _____ Time: _____

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

Red cells: ____# of units: Donor Unit:

FOR CLINICAL SITE USE FOR VERIFICATION OR WHEN TRANSPORTED BY PNEUMATIC TUBE SYSTEM

Complete and return to Facility Blood Bank

Received by: _____ Date: _____ Time: _____