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 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: _____