St. Michael's
Inspired Care.
Inspiring Science.
30 Bond Street
Toronto, Ontario M5B 1W8
(416) 360-4000 **ext. 5084**

PATIENT LABEL

(Please make sure patient NAME, MRN, and DOB are legible.)

TRANSFUSION MEDICINE REQUISITION

PATIENT INFORMATION

DIAGNOSIS: ____________________

Transfused within last 3 months? ☐ No ☐ Yes, **WHERE**? ____________

Previous **antibody (ies)?**: ☐ No ☐ Unable to confirm ☐ Yes, **Antibody**: __________

♀ **Pregnancy:** Grav: ___ Para: ___ **Pregnant?:** ☐ No ☐ Yes, **EDC** ____________

RhIG?: ☐ No ☐ Yes, **WHEN?** _____, **WHERE?**_____________ ☐ unknown

Name of REQUESTING PHYSICIAN or NP

ORDER INFORMATION

BLOOD COMPONENT/PRODUCT(S):

Current patient consent required.

☐ **RBC (units) #____**

Special Requirements: ☐ Irradiated or ☐ ______

☐ Platelets (adult dose) #___________

☐ Frozen Plasma (units) #__________

☐ Cryoprecipitate (units) #__________

☐ Albumin: _____ %, __________ mL

☐ IVIG _____ g *(Requires completed MOHLTC IVIG form)*

☐ RhIG: ________IU

☐ Prothrombin Complex Concentrate (PCC):
_______ IU *(must have current INR)*

TEST(S) REQUESTED:

Shaded areas must be complete

☐ **Group and Screen**

☐ ABO/Rh Verification

☐ DAT (Direct Antiglobulin Test)

☐ Cold Agglutinin Screen (***at 37ºC)***

☐ Cord Blood

☐ Fetal Maternal Haemorrhage Screen (FMH)

☐ Isohemaglutinin Titre(s): Anti-___

☐ Other ____________

☐ *Other (HepB IG, SCIG, C1 Est.) ___________ # vials: ____ size: ______ # treatments:____*

☐ *Factor*: _________ Dose: ______IU x _____ treatments ☐ *Patient Supplies*

☐ *Apheresis: Volume ______mL of 5% Albumin /__CSP /__FP /__SDP*

PATIENT LOCATION

☐ Location: ____________________

☐ O.R./TRANSFUSION DATE: ______________

☐ STAT ORDER (CONFIRM AT EXT. 5084)

☐ Please call ext. _________ when ready

☐ **MTP:** ***One Call to Locating (ext. 5555)***

WAIT for TRANSFER to Transfusion Medicine Lab

SPECIMEN COLLECTION ATTESTATION

I confirm that

1) I performed positive patient identification and patient's name and MRN match the requisition
2) The blood specimens were labeled in patient's presence

Specimen collected by (Last Name, Initial or LIS ID)

TIME collected	**DATE collected**

FOR TRANSFUSION MEDICINE USE ONLY:

TIME STAMP

NAME ON TUBE (LAST NAME, FIRST NAME)								MRN #	
RACK #	ANTI-A	ANTI-B	ANTI-D	D Control	A1C	BC	SOFT UPDATED (✓)	ABO	Rh
LOT # MTS	SCI	SCII	DAT	IgG	C_3	Sal	SOFT UPDATED (✓)	DATE	TECH

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