Print Form

Outpatient Blood Product Booking Request

Name: _____

DOB: _____

PHN: _____

Pt. Phone #: _____

(Use Out Patient IVIG Approval/Booking Request for IVIG)

LAB USE ONLY: Does patient have an antibody card? ☐ No ☐ Yes, copy sent to TML

Diagnosis:_____

Allergies:_____ ☐ None known

Previous transfusion reaction? ☐ No ☐ Yes, describe

Antibiotic resistant organisms: ☐ None ☐ Unknown ☐ MRSA ☐ VRE ☐ ESBL

PICC/SVAD: ☐ No ☐ Yes, location_____

Medication	Medication	Medication

Relevant History:

For transfusion-dependant patient with recurring appointments requested:

Usual day(s) of week transfusion surveillance samples (hematology panel, hold for G&S) drawn:

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Booking Information: Preferred hospital location for infusion(s):_____

Patient **not available**: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Patient absences:_____

Consent for Transfusion of Blood Products:

☐ Accompanies this form ☐ To be signed in outpatient nursing unit

* Physician must have reviewed benefits, risks and alternatives of receiving a blood product with patient.

Urgency:

☐ Urgent (within 72 hours) ☐ Semi-Urgent (within 1 week) ☐ Other (Specify date_____)

Physician last and first name, middle initial	MSP Practitioner #	Physician signature	Date of request

ORDERING PHYSICIAN: Fax completed form (page 1 and 2) to outpatient booking at applicable site.

island health

Outpatient Blood Product Booking Request

Name: _____

DOB: _____

PHN: _____

Pt. Phone #: _____

RED BLOOD CELLS (RBC'S)

Clinical indication (required):

☐ Hgb less than 70 g/L

Hgb 70-90 g/L with:

- ☐ Cardiovascular compromise
- ☐ Bone marrow failure disorder
- ☐ On chemotherapy
- ☐ Other, specify:_____

Special requirement:

- ☐ CMV negative
- ☐ Irradiated
- ☐ Other, specify_____

Single transfusion request:

Adult: _____ unit(s) RBC's

Pediatric: _____ mL RBC's

Hgb:_____ g/L, Date drawn:_____ (must be within 7 days)

Please arrange for sample collection for **blood group and antibody screen** within 3 days of booked date of transfusion.

PLATELETS

Clinical indication (required):

- ☐ Platelet count less than 10 X 10^9/L
- ☐ Bone marrow failure disorder
- ☐ On chemotherapy
- ☐ Other, specify_____

Special requirement:

- ☐ CMV negative
- ☐ Irradiated
- ☐ Other, specify _____

Request:

☐ Adult – I unit Platelets

Pediatric: _____ mL Platelets

Platelet count: _____ X10^9/L, Date drawn: _____ (must be within 48 hours)

RECURRING APPOINTMENTS (Transfusion-dependant patients only. Maximum duration 3 months.)

Reserve MAP/MDC bed for possible transfusion every _____ weeks

If Hgb less than or equal to _____ g/L, give _____ unit(s) RBC's

If Hgb greater than _____ g/L, but less than or equal to _____ g/L give _____ unit(s) RBC's

If platelet count less than or equal to _____ X10^9/L, ☐ give 1 unit Platelets

Must complete **"Clinical indication"** and **"Special requirement"** for applicable blood product(s).

OTHER BLOOD PRODUCT (NOTE: Use Out Patient IVIG Approval/Booking Request for IVIG bookings)

Clinical indication (required):

_____ Type _____ Amount _____

SUPPLEMENTAL TRANSFUSION ORDERS

Physician last and first name, middle initial	Physician phone	MSP Practitioner #
Physician signature	Physician fax	Date of request

BOOKING PERSONNEL

Location of transfusions:	Date/ Time	Date/ Time	Date/ Time
Date/ Time	Date/ Time	Date/ Time	Date/ Time
Date/ Time	Date/ Time	Date/ Time	Date/ Time

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