Calgary ® Laboratory Services

BLOOD COMPONENT/PRODUCT REQUISITION - ADULT

From: PCU (specify)

ORDERING PHYSICIAN: (Include full First and Last Name)

TELEPHONE NUMBER:

Affix addressograph imprint or patient label, or clearly print patient's full name (last name, full first name), Personal Health Number, Regional Health Record Number, date of birth, and gender

FAX NUMBER:	CLINICAL INFORMATION:	BODY WEIGHT: (KG)	PATIENT LOCATION:	REQUISITIONED BY:

As per AHS policy, all faxes must include a fax coversheet.

ORDER DATE: (YYYY-MM-DD)	PRIORITY: ☐ STAT ☐ ASAP ☐ Today	PRODUCT REQUIRED DATE: (YYYY-MM-DD) TIME:(2400 hrs)	REQUESTED BY: (Print Name)

☐ **FMC Transfusion Medicine**	fax: 403-270-7205	☐ **Banff Mineral Springs Hospital Laboratory**	fax: 403-760-7226
☐ **PLC Transfusion Medicine**	fax: 403-291-6895	☐ **Claresholm Hospital Laboratory**	fax: 403-682-3796
☐ **RGH Transfusion Medicine**	fax: 403-301-4084	☐ **Didsbury District Health Services Laboratory**	fax: 403-335-7225
☐ **SHC Transfusion Medicine**	fax: 403-956-1684	☐ **Oilfields Hospital Laboratory**	fax: 403-933-2103
☐ **Canmore Hospital Laboratory**	fax: 403-678-4166	☐ **Strathmore District Health Services Laboratory**	fax: 403-361-7073
☐ **High River Hospital Laboratory**	fax: 403-652-0135	☐ **Vulcan Community Health Centre Laboratory**	fax: 403-485-3350

☐ **Other site (specify)** _____

Blood Components		Volume required
☐ **Red cells ****	**Attributes**	Number of red cell units required:
☐ **Platelets ****	☐ IRRADIATED	Number of platelet doses required:
☐ **Apheresis Platelets**** (For HLA matched contact TM Tech II at 48814)	☐ Volume reduced ☐ Washed	
☐ **Plasma ****		Number of units required:

Blood Products		Volume required
Albumin ☐ 5% 50 mL (2.5 g) ☐ 5% 250 mL (12.5 g) ☐ 5% 500 mL (25 g)	☐ 25% 50 mL (12.5 g) ☐ 25% 100 mL (25 g)	Number of vials:
☐ **Intravenous Immune Globulin** • IVIG History form (TM2038) must be completed for 1st dose. **Instructions to Transfusion Medicine:** _____		**(grams)**
☐ **Rh Immune Globulin**	☐ 300 micrograms (1500 units) ☐ 1000 micrograms (5000 units)	Number of vials:
☐ **Other** (specify)		Quantity/ volume:

**** Use form REQ9004TM if pretransfusion testing has not been completed.**

For TM Use Only			
☐ **PPI** ☐ **ORV** **Initials:**_____	**Blood Group**:	**# Plt doses in 24hrs:**	**Special Transfusion Requirements**: