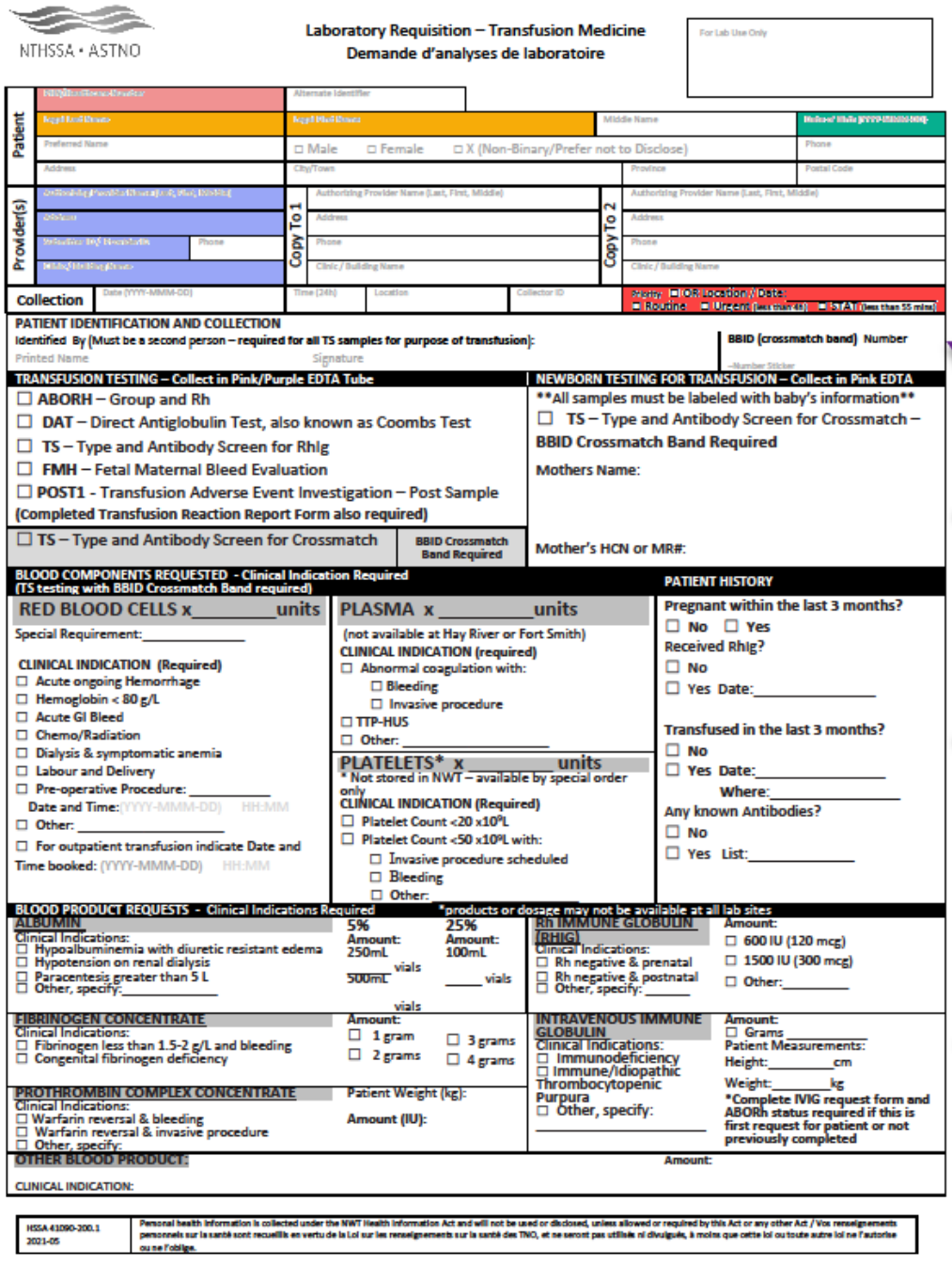
Laboratory Requisition - Transfusion Medicine: NTHSSA 41090-200.1 2021-05



NTHSSA • ASTNO

Laboratory Requisition – Transfusion Medicine
Demande d'analyses de laboratoire

For Lab Use Only

Patient

Alternate Identifier
Middle Name
☐ Male ☐ Female ☐ X (Non-Binary/Prefer not to Disclose)
Phone
City/Town
Province
Postal Code

Provider(s)

Copy To 1
Copy To 2
Authorizing Provider Name (Last, First, Middle)
Address
Phone
Clinic / Building Name

Collection

Date (YYYY-MMM-DD)
Time (24h)
Location
Collector ID
Priority ☐ OR Location / Date:
☐ Routine ☐ Urgent (less than 4h) ☐ ASAP (less than 55 mins)

PATIENT IDENTIFICATION AND COLLECTION
Identified By (Must be a second person – required for all TS samples for purpose of transfusion):
Printed Name
Signature
BBID (crossmatch band) Number
Number Sticker

TRANSFUSION TESTING – Collect in Pink/Purple EDTA Tube

☐ **ABORH** – Group and Rh
☐ **DAT** – Direct Antiglobulin Test, also known as Coombs Test
☐ **TS** – Type and Antibody Screen for Rhlg
☐ **FMH** – Fetal Maternal Bleed Evaluation
☐ **POST1** - Transfusion Adverse Event Investigation – Post Sample
(Completed Transfusion Reaction Report Form also required)
☐ **TS** – Type and Antibody Screen for Crossmatch — BBID Crossmatch Band Required

NEWBORN TESTING FOR TRANSFUSION – Collect in Pink EDTA

All samples must be labeled with baby's information
☐ **TS** – Type and Antibody Screen for Crossmatch – **BBID Crossmatch Band Required**
Mothers Name:
Mother's HCN or MR#:

BLOOD COMPONENTS REQUESTED - Clinical Indication Required
(TS testing with BBID Crossmatch Band required)

RED BLOOD CELLS x_____units
Special Requirement:_____
CLINICAL INDICATION (Required)
☐ Acute ongoing Hemorrhage
☐ Hemoglobin < 80 g/L
☐ Acute GI Bleed
☐ Chemo/Radiation
☐ Dialysis & symptomatic anemia
☐ Labour and Delivery
☐ Pre-operative Procedure: _____
Date and Time: (YYYY-MMM-DD) HH:MM
☐ Other: _____
☐ For outpatient transfusion indicate Date and Time booked: (YYYY-MMM-DD) HH:MM

PLASMA x _____units
(not available at Hay River or Fort Smith)
CLINICAL INDICATION (required)
☐ Abnormal coagulation with:
☐ Bleeding
☐ Invasive procedure
☐ TTP-HUS
☐ Other: _____

PLATELETS* x _____units
* Not stored in NWT – available by special order only
CLINICAL INDICATION (Required)
☐ Platelet Count <20 x10⁹/L
☐ Platelet Count <50 x10⁹/L with:
☐ Invasive procedure scheduled
☐ Bleeding
☐ Other:

PATIENT HISTORY

Pregnant within the last 3 months?
☐ No ☐ Yes
Received Rhlg?
☐ No
☐ Yes Date:_____
Transfused in the last 3 months?
☐ No
☐ Yes Date:_____
Where:_____
Any known Antibodies?
☐ No
☐ Yes List:_____

BLOOD PRODUCT REQUESTS - Clinical Indications Required *products or dosage may not be available at all lab sites

ALBUMIN
Clinical Indications:
☐ Hypoalbuminemia with diuretic resistant edema
☐ Hypotension on renal dialysis
☐ Paracentesis greater than 5 L
☐ Other, specify:_____
5% Amount: 250mL _____ vials; 500mL _____ vials
25% Amount: 100mL _____ vials

FIBRINOGEN CONCENTRATE
Clinical Indications:
☐ Fibrinogen less than 1.5-2 g/L and bleeding
☐ Congenital fibrinogen deficiency
Amount:
☐ 1 gram ☐ 3 grams
☐ 2 grams ☐ 4 grams

PROTHROMBIN COMPLEX CONCENTRATE
Clinical Indications:
☐ Warfarin reversal & bleeding
☐ Warfarin reversal & invasive procedure
☐ Other, specify:
Patient Weight (kg):
Amount (IU):

Rh IMMUNE GLOBULIN (RHIG)
Clinical Indications:
☐ Rh negative & prenatal
☐ Rh negative & postnatal
☐ Other, specify:_____
Amount:
☐ 600 IU (120 mcg)
☐ 1500 IU (300 mcg)
☐ Other:_____

INTRAVENOUS IMMUNE GLOBULIN
Clinical Indications:
☐ Immunodeficiency
☐ Immune/Idiopathic Thrombocytopenic Purpura
☐ Other, specify:
_____
Amount:
☐ Grams _____
Patient Measurements:
Height:_____cm
Weight:_____kg
*Complete IVIG request form and ABORh status required if this is first request for patient or not previously completed

OTHER BLOOD PRODUCT:
Amount:
CLINICAL INDICATION:

HSSA 41090-200.1 2021-05

Personal health information is collected under the NWT Health Information Act and will not be used or disclosed, unless allowed or required by this Act or any other Act / Vos renseignements personnels sur la santé sont recueillis en vertu de la Loi sur les renseignements sur la santé des TNO, et ne seront pas utilisés ni divulgués, à moins que cette loi ou toute autre loi ne l'autorise ou ne l'oblige.

Patient Name

Health Care number

Birth date

Ordering Provider and Location

Test Priority

Secondary Identifier information - different then collector and BBID number

Tests Ordered

Patient History and Blood Component Orders

Blood Product Orders