Community Paramedic In-home Transfusion Criteria & Information

The Community Paramedic Program accepts in-home blood transfusion (RBC, platelets and albumin) referrals for medically fragile people residing within Calgary city limits.

To be considered eligible for this service:

- Your patient must have received previous transfusion(s) without serious complications;
  - *a)* The patient must have received at least two (2) transfusions within the previous 120 days without serious complications; or
  - *b)* More than four (4) transfusions within the previous year without serious complications; or
  - *c)* At the discretion of Transfusion Medicine physician lead.
- Your patient must be able to tolerate infusion rates between 90 – 120 minutes per unit of RBC
- The order must not exceed 2 units of RBCs and 1 dose of platelets
- The referral must be received at least 24 hours prior to the requested transfusion date
- CBC and type & screen, if applicable must be completed and interpreted within 96 hours of the requested transfusion date

NOTE: if your patient requires re-occurring transfusions, the requesting physician must submit a new referral for each transfusion request after reviewing a CBC drawn within 2 weeks.

Please confirm your patient meets at least one of the following criteria at the time of the referral or speak directly with the patient coordinator to review the circumstances around your patient:

- Patient has a mental health problem such as agoraphobia, debilitating anxiety, or psychiatric condition that prevents them from leaving their residence
- Patient has dementia or brain injury that would present as a safety risk travelling to a facility
- Patient suffers from a medical condition such that a trip of an hour or more outside of the home would compromise the patient's health
- Patient has high oxygen requirements that cannot be safely met by the use of portable oxygen

NOTE: All transfusion referrals, are subject to review by AHS Calgary Zone Transfusion Medicine

Please call 1-855-491-5868 to speak with the patient coordinator if you have any questions.

Web: https://www.albertahealthservices.ca/ems/Page15295.aspx
Email: CommunityParamedic@albertahealthservices.ca

Phone: 1.855.491.5868
Fax: 403.776.3835

Community Paramedic In-home Transfusion Criteria & Information

Your request will be **delayed** until all required documentation has been completed and faxed to 403-776-3835.
Please review patient eligibility criteria to ensure the referral is appropriate for community infusion.
Please call 1-855-491-5868 to confirm your faxed referral has been received and all necessary information is included.

Required Documents:

1. **Community Paramedic Referral Form**
2. **Consent Form**
3. **Blood Component / Product Requisition Form**

Community Paramedic Referral Form **must** include:

- Rate of infusion
- Sequence of infusion if more than one type of blood component and product is being transfused

Consent to Treatment / Procedure Form **must** include signatures:

- Prescribing physician and patient signature OR the telephone consent signed by the physician and witness.

Blood Component / Product Requisition Form **must** include:

- Units of blood requested and Attributes if any.

Web: Community Paramedic Referral Directory

Web: http://www.albertahealthservices.ca/info/Page15295.aspx
Email: CommunityParamedic@albertahealthservices.ca

Phone: 1.855.491.5868
Fax: 403.776.3835

Alberta Health Services

Community Paramedic Response Team Referral

- Fax completed form and supporting documents *(as required)* to

☐ Patients **in and North of Red Deer**
Fax: 780.735.0421
Call: 1.833.367.2788

☐ Patients **South of Red Deer**
Fax: 403.776.3835
Call: 1.855.491.5868

- Call to confirm that your fax has been received; Incomplete referrals will not be processed
- Services and availability may vary by Zone
- **Physician must be available to Community Paramedics by phone at the time of treatment**

When does Patient need to be seen? ☐ Today ▶ **For same day treatment**, **call ahead for availability**
☐ Date *(yyyy-Mon-dd)* _____

Additional / Follow Up Dates Required *(yyyy-Mon-dd)* _____, _____, _____

Patient Information

Last Name	First Name	Date of Birth *(yyyy-Mon-dd)*

Gender	PHN	Phone	Alternate Phone

Site and/or Address where patient will be for treatment

Allergies ☐ No Known Allergies ☐ List attached

Is Patient a current client of other care providers? *(eg. Home Care)*
☐ Unknown
☐ No
☐ Yes, *specify* _____

Goals of Care Designation
☐ Unknown ☐ None ☐ R1 ☐ R2 ☐ R3 ☐ M1 ☐ M2 ☐ C1 ☐ C2

Does patient have Central Venous Access Device?
☐ No ☐ Yes ▶ **Attach catheter insertion record with CVC tip verification**

Referral Information

Reason for Referral *(Include Diagnosis or History relevant to referral)*

Physician Orders *(Include: dose, route, rate/volume, frequency and duration as applicable)*

☐ _____

☐ _____

☐ _____

☐ _____

▶ **Attach List of Current Medications and Additional Orders** ***(if required)***

Tests Required *(Check all that apply)*

Community Paramedics will assess Vital Signs on arrival for all patients (*GCS, HR, RR, Temp, Blood Pressure, SpO_2)*

☐ $ETCO_2$ ☐ JVP ☐ Weight ☐ Blood Glucose Level
☐ 12/15 Lead ECG *(not interpreted by a cardiologist)* ☐ Swab/Specimen Collection ▶ **Attach requisition**

Referral Source

Clinic/Site Name	Clinic/Site Contact Name	Direct Phone	Fax

Physician Name	Direct Phone	Cell	Pager

Signature	Date *(yyyy-Mon-dd)*	Please consult Physician ☐ during visit ☐ after visit

BLOOD COMPONENT/PRODUCT REQUISITION - ADULT

From: PCU (specify)

ORDERING PHYSICIAN: (Include full First and Last Name)

TELEPHONE NUMBER:

FAX NUMBER:

Affix addressograph imprint or patient label or clearly **print** patient's full name (last name, full first name), date of birth, gender, Personal Health Number, Medical Record 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** ❑ Irradiated ❑ CMV negative ❑ Volume reduced ❑ Washed	Number of red cell units required:
❑ **Platelets** ** ❑ **Apheresis Platelets**** (For HLA matched contact TM Tech II at 48814)		Number of platelet doses required:
❑ **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**	Group	Special Transfusion Requirements

Alberta Health Services

Name (last, first)	
Birthdate (yyyy-Mon-dd)	Gender ☐ M ☐ F
PHN/ULI	

Consent to Treatment Plan or Procedure

(Policy PRR-01)

Instructions: If the person providing consent disagrees to an item on this consent form, strikeout the text and have them initial beside it.

Patient Name

Details of Treatment Plan or Procedure *(write in full without abbreviations)*

I confirm that the nature, benefits, risks, consequences, and alternatives of the treatment plan or procedure *(as detailed above)* and related matters have been explained to me. I am satisfied with and understand the information I have been given, and I consent to the treatment plan or procedure.

_____ *(name/service)* will perform this treatment plan or procedure with the assistance of any other healthcare practitioners including medical students, residents and others in training.

I understand that I may, at any time, withdraw consent to this treatment plan or procedure *(as detailed above)* or any other related matter.

Name of person(s) providing consent	Specify role of person(s) providing consent
Phone #	☐ Patient (adult) ☐ Parent (with legal authority to consent) ☐ Patient (mature minor) ☐ Co-decision Maker ☐ Agent ☐ Guardian/Legal Representative ☐ Specific Decision Maker *(relationship to Patient)* _____

Signature of person providing consent	Date *(yyyy-Mon-dd)*	Time
Signature of Co-decision Maker *(if applicable)*	Date *(yyyy-Mon-dd)*	Time

Note: When an individual other than the patient provides consent, a copy of the court order, personal directive, or other document authorizing them to do so must be kept on the health record.

Witness Statement

I observed the person providing consent sign the consent form *(Witness must be at least 18 years of age)*

Witness name *(print)*	Signature	Date *(yyyy-Mon-dd)*	Time

Most Responsible Health Practitioner Statement

I have explained the treatment plan or procedure to the person providing consent. In my opinion, this person understands the nature, benefits, risk, consequences, and alternatives.

Name	Signature	Date *(yyyy-Mon-dd)*

If the person obtaining consent has been delegated to do so by the Most Responsible Health Practitioner, specify role ☐ Physician ☐ Resident	Time

Alberta Health Services

Name (last, first)	
Birthdate (yyyy-Mon-dd)	Gender ☐ M ☐ F
PHN/ULI	

Consent to Treatment Plan or Procedure

(Policy PRR-01)

Telephone Fax Consent

Consent was given via ☐ Telephone ☐ Fax/Scan

Name of Most Responsible Health Practitioner	Signature	Date (yyyy-Mon-dd)	Time
Witness Name *(to telephone call)*	Signature	Date (yyyy-Mon-dd)	Time

Interpreter

Obtaining Consent from a Non-English Speaking Patient

I acknowledge that I have interpreted the information given to me about the treatment plan or procedure and the content of this consent form to the person giving consent and I believe to the best of my ability that the person understands the information.

Interpreter name *(print)*	Signature or *"by telephone"*	Date (yyyy-Mon-dd)	Time

Withdrawal of Consent

☐ I withdraw my consent for the **entire** treatment plan or procedure as detailed on Side A. I am aware of the risks and consequences of this withdrawal.

☐ I withdraw my consent for the following specific portions of the treatment plan or procedure. I am aware of the risks and consequences of this withdrawal.

Name of person withdrawing consent	Signature	Date (yyyy-Mon-dd)	Time

Note: Health practitioner who has documented the withdrawal of consent should inform the Most Responsible Health Practitioner of the withdrawal of consent to the treatment plan or procedure.

Definitions

Legal Representative: acting on behalf of a Minor Patient under the age of 18 years who is not determined to be a Mature Minor *(Guardian; divorced parent with custody; person appointed by Guardian to act on behalf of Guardian where Guardian is temporarily absent; any other person authorized by law to consent).*

Agent: an adult appointed in an enacted personal directive in accordance with the *Personal Directives Act.*

Guardian: an adult appointed in a Guardianship Order to act on behalf of an adult patient.

Specific Decision Maker: an adult relative selected to act on behalf of a patient when a patient lacks capacity and an Alternate Decision Maker is not already identified *(Guardian or Agent).* There is a specific process and form *(AGTA Form 6)* to follow for selecting a Specific Decision Maker in accordance with the *Alberta Guardianship and Trusteeship Act.*

Co-Decision Maker: appointed by court order to assist an adult whose ability to make decisions is severely impaired, but who can still make decisions with good support. The Adult and Co-Decision Maker are required to make decisions together and both sign the appropriate consent form when written *(signed)* consent is required or the Most Responsible Health Practitioner has determined the need for written *(signed)* consent.