ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Transfusion Medicine Requisition

Alberta Precision Laboratories 1-877-868-6848
Appt Booking & Locations: www.albertaprecisionlabs.ca
Important - Form is used for regular and downtime use. ***Bold*** and ***italicized*** fields contain critical data elements that must be reconciled for downtime.

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: ________	Date of Birth *(dd-Mon-yyyy)*	
Legal Last Name	Legal First Name	Alternate Identifier

Middle Name	Preferred Name	☐ Male ☐ Female ☐ X Non-binary/Prefer not to disclose	Phone

Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Priority ☐ Routine ☐ Stat

Downtime Number

Clinical Information - Required

Indication for Test/Transfusion

Transfusion Date

Pregnant last 90 days? ☐ Yes ☐ No ☐ Unknown
Transfused last 90 days? ☐ Yes ☐ No ☐ Unknown
Hospitalized outside AB last 90 days? ☐ Yes ☐ No ☐ Unknown

Transfusion Location

☐ Pre Op
Surgery Date *(dd-Mon-yyyy)* ____________________

Pre/Post transfusion Testing *TSIN Required*

☐ Type and Screen

(Connect Care downtime only)
☐ Draw and Hold (Edmonton only)

Pre/Post-natal Testing

Prenatal Screening - Use CBS Perinatal Testing Requisition

☐ RhIG Eligibility (Prenatal)

☐ Postnatal evaluation (Mother)

☐ Neonatal evaluation (Cord)

Mother's pMRN ____________________

Mother's Name ____________________

Mother's ABORh ____________________

Prepare – Blood Products/Derivatives

☐ Red Blood Cells Number of Units __________

(Connect Care Downtime Only)

☐ Plasma Number of Units __________
☐ Platelets Number of Units __________
☐ RhIG
☐ 300 µg ☐ Other ____________
☐ Albumin
☐ 25% ☐ 5%
Volume (ml) __________
☐ IVIG Dose (g) __________
☐ PCC Dose (IU) __________
☐ Fibrinogen Dose (g) __________
☐ Other/Comments

Other Tests (Not for Transfusion)

☐ Direct Antiglobulin Test
Hemolysis suspected? ☐ Yes ☐ No
☐ ABORH
☐ Antibody Screen
☐ Transfusion Reaction Investigation ****Contact TM Immediately***

Other Tests/Comments

Transplant Team Only

Isohemagglutinin titre
☐ For peri-transplant surveillance
☐ Immune status