Alberta Health Services

Regional Blood Transfusion Service Requisition

ABO-1 Accn #

Accession # *(lab only)*

Patient

PHN	Alternate Identifier		Date of Birth *(yyyy-Mon-dd)*	
Last Name	First Name	Middle	Gender ☐ M ☐ F	Phone
Address	City/Town	Prov	Postal Code	Location

Requestor (s)

Requestor Name *(last, first)*	Copy to *(last, first)*	Copy to *(last, first)*
Location/Facility/Address	Location/Facility/Address	Location/Facility/Address
Phone	Phone	Phone
Healthcare Provider ID	Healthcare Provider ID	Healthcare Provider ID

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

REQUIRED
☐STAT
☐ 1 – 4 h
☐ Routine

Date and Time Needed for Transfusion
_____
(YYYY-MMM-DD) Time (24h)

To be transfused at *(Location)* _____

BASIC CLINICAL INFORMATION

Diagnosis/Procedure _____

_____

Bill Type
CPL ☐ Alberta Health Care
CCO ☐ Alberta Health Services
COO ☐ Company Bill Other
AX ☐ Auxiliary XX ☐ Pre-paid
OT ☐ Out of Prov PB ☐ Patient Bill
Co. name_____
Address _____
Client # _____

Collected by *(signature)*

Identified by *(signature)*

BBIN

Patient Weight (kg)		**Patient Height (cm)**		For Lab Use Only	BIQ ☐ _____ NetCare ☐ _____ Other ☐ _____

TEST REQUEST

PRETRANSFUSION (BBIN required)

INFORMED CONSENT DOCUMENTED
☐ Yes ☐ No

TYSH/XM ☐ Type and screen /Crossmatch (complete Product Request below)

DRHO ☐ Draw only (no testing done)

ABID ☐ Antibody Identification

Required history taken by: _____

Pregnant within last 3 months (PHI)
☐ Yes ☐No ☐Unknown

Transfused within last 3 months (THI)
☐ Yes ☐No ☐Unknown

NON-TRANSFUSION RELATED

(BBIN not required)

ANEV ☐ Perinatal ABORh for RhIG eligibility
RHEV ☐ Postpartum ABORh for RhIG eligibility
NEV ☐ Neonatal ABORh only Mom's ULI _____
DABO ☐ ABO and Rh (3rd Party)
ABORH ☐ ABO and Rh (Medical)
CABO ☐ Confirmatory ABORh (Lab)
ABSCR ☐ Antibody Screen (indirect coombs)
DAT ☐ Direct Coombs
TRXN ☐ Transfusion Reaction Investigation
IGT ☐ Iso Hemagglutinin titres
AIGA ☐ IgA Antibodies
OTHER ☐ _____
(specify)

IDENTIFICATION & LABELING MUST BE DONE AT PATIENT'S SIDE

PRETRANSFUSION COLLECTION

a First individual **identifies patient** requisition vs. armband or ID. **Patient information must agree. Identifier signs requisition.**

b Second individual collects specimen and labels with: full first name and last name, ULI or ID#, date and time of collection. Requisition & specimen **must agree**.

c Collector band patient with BBIN.

d Apply BBIN label to specimen and requisition.

e **Collector signs requisition** and records date and time collected on requisition.

NON-TRANSFUSION RELATED COLLECTION

a **Identify patient** requisition vs. armband or ID. **Patient information must agree.**

b Collect specimen and label with: Full first name and last name, ULI or ID#, date and time of collection. Requisition & specimen **must agree**.

c **Collector signs requisition**

BLOOD PRODUCT REQUEST

UNMATCHED BLOOD M.D. RESPONSIBLE
_____
(signature of ordering MD or designate)
_____ units

RED CELLS [BBIN required]
Adults _____ units (280 mL/unit)
Peds/neonates _____ mL
or _____ units

PLASMA [BBIN required]
Adults _____ units (200 mL/unit)
Peds/neonates _____ mL

PLATELETS [BBIN required]
☐ pooled random donor (340 mL/unit)
☐ apheresis (300 mL/unit)
Adults _____ units
Peds/neonates _____ mL

INDICATIONS
(Other relevant clinical information)

Hgb _____

INR _____
Anticoagulants? _____

Platelet count: _____
☐ is bleeding ☐ post-op ☐ pre-op
☐ was on pump
☐ has received more than one blood volume transfusion in the past 24 h

OTHER PRODUCT REQUESTS

PRODUCT REQUESTED		TOTAL DOSE	
☐ Albumin	☐ 5% ☐ 25%	(mL)	Date/Time Received
☐ IVIG		(grams)	
☐ RhIG	☐ 120 µg ☐ 300 µg ☐ 1000 µg	(µg)	
☐ Other (May require SAP authorization)			

Regional Blood Transfusion Service Requisition

Name
ULI #
BBIN #
Patient Comments

Test	Accn#	Date	SET UP BY		READY BY		Final Reading at
			Initials	Tech ID	Initials	Tech ID	
ABO/Rh Type							
SCREENING							
DAT							

Date / Time IN
Date / Time OUT

ABO / Rh TYPE		ANTI		CELLS		ANTI					INTERPRETATION	
Test/Method	Accn #	A	B	A1	B	D (series 4)	D (series 5)	Control	RH IAT	CC	ABO	RH

SCREENING METHOD→						
TEST CELLS ↓						
SI						
SII						
SIII						

DAT				
Accn #	IS	5 min	CC	Interpretation
Poly				
IgG				
C3				
PBS				

XM						
METHOD→						Tech ID
DONOR # ↓						

PRODUCT ISSUE					
Product Ordered	Accn #	Order Date & Time	Ward	Time Out (completed)	Tech ID