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	Transfusion Location

Pre-transfusion Testing *TSIN Required*
(Connect Care downtime only)

☐ Type and Screen ☐ Draw and Hold

Routine Pre-natal Screening

Use **CBS Perinatal Testing for Red Cell Serology Requisition** *(blood.ca/en/requisitions-and-forms)*

☐ Pre-Op Testing Order Hospital ________________
Scheduled Surgery Date *(dd-Mon-yyyy)* ________________
Has the patient been pregnant in last 90 days?
☐ Yes ☐ No ☐ Unknown
Has patient been transfused outside Alberta in the last 90 days?
☐ Yes ☐ No ☐ Unknown

Management of Acute Perinatal Loss/Bleed/Delivery

☐ RhIG Eligibility (includes ABO/Rh and ABSC)
☐ Postnatal evaluation (Mother)
☐ Neonatal evaluation (Cord)

Mother's pMRN ________________
Mother's Name ________________
Mother's ABORh ________________

Prepare Orders *(Connect Care downtime only)*

Blood Components (Connect Care Downtime Only)

☐ Red Blood Cells
Units ________ ***or*** mLs ________ *(dosing 10-15mLs/kg)*
Hgb ________ Indication ________

☐ Plasma
Units ________ ***or*** mLs ________ *(dosing 10-15mLs/kg)*
INR ________ Indication ________

☐ Platelets
Units ________ ***or*** mLs ________ *(dosing 10-15mLs/kg)*
Plt ________ Indication ________

Transplant Team Only

☐ ABORH
☐ Antibody Screen
☐ Isohemagglutinin Titre
  ☐ For peri-transplant surveillance
☐ Immune status

Other Tests

☐ Direct Antiglobulin Test
  Hemolysis suspected? ☐ Yes ☐ No
☐ Transfusion Reaction Investigation
  *Contact TM Immediately
☐ Red Cell Genotyping/Phenotyping
  Indication ________________
☐ Other ________________

Blood Derivatives

☐ RhIG
  ☐ 300 μg ☐ Other
☐ Albumin
  ☐ 25% ☐ 5% Volume (mL) ________
☐ IVIG
  Dose (g) ________ Indication ________________
  Weight________ Height ________
☐ PCC
  Dose (IU) ________ Type of Anticoagulant ________________
  INR (Vit K antag)________ or Anti-Xa (DOAC) ________________
☐ Fibrinogen
  Dose (g)________ Indication ________________
  Fibrinogen level ________________
☐ Other/Comments ________________