P0003FXS

Blood product request

Sections in orange are mandatory

Patient Label

Name: ______________________

NHI: ____________ DOB: ____________ (dd/mm/yy)

Address: ______________________

or patient details

Transfusion is:	Prescribing clinician
☐ **CRITICAL / URGENT:** Ring Blood bank on 98472	Print name: ____________
☐ **PLANNED:** Date ________ (dd/mm/yy) Time ________ (24 hour)	
Deliver to: ____________	Registration number: ____________

Name of person completing form: ____________

Contact phone: ____________

Product/s required details NON-URGENT OVERNIGHT TRANSFUSION NOT RECOMMENDED

SINGLE UNIT GUIDELINE APPLIES for: Stable/normovolaemic, non-bleeding adult

Red cells		
☐ Adult ☐ Paediatric	☐ Symptomatic anaemia	☐ Active/recent bleeding
Hb = ______	☐ Asymptomatic anaemia	☐ Peri surgery/procedure
No. ______ units required **NOW**	☐ Acute coronary syndrome	☐ Chronic recurrent transfusion
		☐ Other ____________

Platelets		
Platelet count = ______	☐ Platelet dysfunction + bleeding	☐ Platelet dysfunction + pre surgery
Quantity ______ units	☐ ITP and bleeding or risk of bleeding	☐ DIC
	☐ Platelet count <$10x10^9$/L	☐ Other
	☐ Platelet count <$20x0^9$/L and bleeding and/or septic	

Fresh frozen plasma			
Quantity ______ units	☐ Active bleeding	☐ Acute DIC	☐ Other ______
	☐ Factor deficiency	☐ Abnormal coags and bleeding	☐ Warfarin reversal – life threatening bleeding
	☐ Pre surgery/procedure		

Cryoprecipitate		
Fibrinogen level = ______	☐ Active bleeding due to low Fibrinogen	☐ Post cardiac surgery and bleeding
Quantity ______ units	☐ Abnormal coagulation no bleeding	☐ Pre surgery/procedure
	☐ Factor deficiency	☐ Other

NB: NOT VIA LAMSON

Prothrombinex (500IU/vial) *(Please phone Blood Bank)*			
INR ______	☐ Warfarin reversal	☐ Rivaroxaban reversal	☐ Other
Quantity ______ vials			

Albumex x 4% ☐ 50ml 2g ☐ 500ml 20g			
Quantity ______ vials	☐ Hypoalbuminemia	☐ Burns	☐ Other
Albumex x 20% ☐ 10ml 2g ☐ 100ml 20g	☐ Volume depletion	☐ Liver disease	☐ Cardiac bypass prime
Quantity ______ vials			

Other product/s required details

NB: NOT VIA LAMSON	**RhD Ig 625IU *(Anti D)***	**Tetanus immunoglobulin**
IVIG (INTRAVENOUS IMMUNOGLOBULIN)	Quantity ______ vials	Quantity ______ iu
☐ **Intragam**	**RhD Ig 250IU *(Anti D)***	**Other:**
☐ **Privigen**	Quantity ______ vials	**NB: FOR LAMSON COMPATIBILITY** see page 2
Quantity ______ gms	**HyperHepB Ig**	______
Ensure NZBS approval has been sent	Quantity ______ vials	______

Blood Bank use only	Specimen number (if required) ______
Date (dd/mm/yy)	Signature

Send this form to Blood Bank when requiring blood components or products. To be retained at Blood Bank.

BLOOD PRODUCT REQUEST

Waikato District Health Board

Blood product request

BLOOD PRODUCT REQUEST

Products that ***cannot*** be sent through approved Lamson stations
Please organise collection

- Biostate (Factor VIII) 500IU & 1000IU
- Prothrombinex VF 500IU
- Thrombotrol VF 1000IU
- Albumex 4% 50ml / 500ml
- Albumex 20% 100ml
- Intragam P 50ml / 200ml
- Privigen IVIg 5g / 10g / 20g
- Evogam 5ml / 20ml
- Fibrogammin (FXIII)
- Berinert P 500IU
- Riastap 1g
- Feiba 500IU
- Hizentra 20ml
- Novoseven 1mg / 2mg / 5mg
- Benefix 500 IU / 1000IU / 2000IU
- Xyntha 250IU / 500 IU / 1000IU / 2000IU
- Rixbuis
- Alprolix