BC Children's Hospital
An agency of the Provincial Health Services Authority

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

TRANSFUSION MEDICINE LABORATORY

BLOOD COMPONENT/DERIVATIVE/ FACTOR CONCENTRATE REQUEST

Diagnosis: _____ **Location:** _____

ORDERING PHYSICIAN NAME: (Please Print) _____

REASON FOR REQUEST: _____

DATE REQUIRED ☐ Today ☐ Other ☐ Pre-Op Date_____

PRIORITY ☐ Routine ☐ ASAP <2 Hr. ☐ STAT <30 min.

BLOOD COMPENENTS

FOR DOSING AND OTHER PRODUCT INFORMATION SEE FACT SHEETS IN ePOPS

☐ PLATELETS

☐ Adult dose (approx 300 mL) OR _____mL

Special Requirements

☐ Irradiated

☐ Other _____

☐ CRYOPRECIPITATE (5-15 mL/unit) order in units only

_____units

PLASMA

☐ **Frozen Plasma** (150-200 mL/unit)

Units _____ OR Volume _____ mL

☐ **Cryosupernatant Plasma (200-300 mL/unit)**

Units _____ OR Volume _____ mL

PLASMA DERIVATIVES

☐ **5% Albumin** _____ **mL**

☐ **25% Albumin** _____ **mL**

☐ **Intravenous Immune Globulin (grams)**

Patient Weight: _____ kg

Dosage: _____ g/kg

Total: _____ g

☐ **RH Immune Globulin**

☐ 600 IU (120 ug) ☐ 1500 IU (300 ug) OR _____IU

☐ **Hepatitis B Immune Globulin**

☐ 0.5 mL OR _____ mL

☐ **Varicella Zoster Immune Globuline**

(dosage: 1 vial/10 kg to max. 5 vials)

Patient Weight: _____ kg

Total number of vial: _____

Administration Route:

☐ IM

☐ IV

☐ **Other:**

Product: _____

IU: _____

FACTOR CONCENTRATE

☐ **Antihemophilic Factor** (recombinant)

_____ IU

Specify brand when required: _____

☐ **Factor IX** (recombinant)

_____ IU

☐ **Factor VIIa** (recombinant)

_____ IU

☐ **Other Factor Concentrates:**

Product: _____

IU: _____