**Patient location:** _____

**Phone extension:** _____

*Addressograph area*

**REQUEST FOR BLOOD OR TISSUE PRODUCTS**

INSTRUCTIONS

1. Addressograph top right corner of form, ensuring patient name and PIN are legible.
2. Complete section above with location and phone extension where blood / tissue is to be sent.
3. Call the UH BTL at ext **33441;** fax voucher to UH BTL (fax # **33798)**

LSG London Laboratory Services Group

# ISSUE VOUCHER FOR BLOOD AND TISSUE PRODUCTS

**ORDERING PHYSICIAN:** _____

**Voucher completed/reviewed by:** _____
SIGNATURE OF NURSE

☐ **Signed consent for transfusion of blood and/or blood products is in the patient's chart.**

**Nurse's initials:** _____

## CLINICAL INDICATIONS FOR TRANSFUSION:

☐ O.R. ☐ Abnormal Test Result (specify): _____

☐ Patient bleeding ☐ Other (specify): _____

## PRODUCT REQUIRED: ☐ ASAP ☐ Date/time: _____

☐ Packed red cells _____ units or mL

☐ Fresh frozen plasma _____ units or mL

☐ Platelets ☐ Adult dose ☐ Pediatric dose _____mL

☐ 25% Albumin ☐ 100mL x ____ ☐ 50mL x ____

☐ 5% Albumin ☐ 250mL x ____ ☐ 500mL* x ____

**NOTE: Order 500mL size only if infusion rate > 125 mL/h**

☐ IV Immune Globulin (IVIG) _____ g

☐ Rh Immune Globulin (RhIg) _____ mcg

☐ Octaplex (PCC) Patient weight: _____kg

☐ Voluven _____ mL

☐ Other (specify): _____

☐ **TISSUE PRODUCT (specify):**

_____

***For BTL Use Only:***

**Transport Container #** _____

**Return Time** _____