SPECIAL REQUEST ORDER FORM

This order form must be faxed. Please place in the Hospital Customer Portal if the equivalent form exists. DO NOT USE THIS FORM FOR HLA/HPA SELECTED Platelets for IUTs - USE FORM F800046 Request for HLA/HPA Selected Platelets

Canadian Blood Services — BLOOD PLASMA STEM CELLS ORGANS & TISSUES

Section I: Requesting Hospital Details and Patient Information (complete for all request types)

Request Date (YYYY-MM-DD):

Required Date and Time: N/A

☐ STAT*
☐ ASAP
☐ Routine

Requesting Hospital Name:

Ship to Hospital Address:

Hospital Contact :

Email: Phone #: Fax #:

Ordering / Transfusion Physician:

Email: Phone #: Fax #:

*STATs must be faxed and phoned in.

Choose One:

☐ **Patient Specific Request (Please complete the below)** **OR** ☐ **Stock Only**

Last Name: First Name:

Date of Birth (YYYY-MM-DD): Province/Territory of Residence: BC

Provincial/Territorial Health Card Number:

Does the Patient have Sickle Cell Disease? Blank

Patient's ABO Rh: Patient Antibodies:

Are ABO compatible substitutions acceptable? Blank Are Rh compatible substitutions acceptable? Blank

If ABO/Rh substitutions are not acceptable, please indicate why:

Note: CBS may initiate site transfers or donor recruitment to locate appropriate units. Lead times may be extended if this is required

Section II: Special Red Blood Cell Requests ☐ **N/A**

Required Negative Antigens**:**

☐ C	☐ E	☐ (c)	☐ e	☐ K	☐ Fy^a	☐ Fy^b	☐ Jk^a	☐ Jk^b	☐ S	☐ (s)

Other:

Additional Requirements (Please include donor numbers if MMA performed):

☐ Irradiated ☐ Washed ☐ Extra Washed[1] ☐ IUT, CMV Neg **not** required. ☐ IUT, CMV Neg **required.** ☐ Other (Please add comment)

Comments:

Unit age Requirements[2]: Less than N/A Days old or ☐ N/A Amount_____ (Number)

Note: [1]Extra washed units are appropriate for patients with a history of severe allergic reactions related to anti-IgA antibodies. If an IgA deficient RBC is available, it will be delivered as a substitution.

[2]Units will be prioritized to meet negative antigen requirements over age requirements if components meeting all criteria are not available. This section should only be used for IUTs and irradiation.

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Canadian Blood Services BLOOD PLASMA STEM CELLS ORGANS & TISSUES

Section III: Special Platelet Requests ☐ N/A

☐ **Apheresis Platelets in PAS (Non-Psoralen Treated)**

Note[1]For HLA/HPA Selected Platelets Please use form F800046 *Request for HLA/HPA Selected Platelets*
Note[2]: All Platelets that are not psoralen treated are irradiated unless otherwise requested.

Please list any other testing or modifications: ☐ **N/A**

Amount _____ (Number)

Please select rationale: ☐ IUT ☐ Psoralen Allergy ☐ Other(Please add comments below)

Comments (**Required when selecting "other" for rationale when requesting Platelets in PAS):**

Section IV: For CBS Use Only ☐ N/A

☐ Medical Consultation Required Or ☐ Rare Blood Program Inquiry only

Reason for Medical Consult/Rare Blood Consult (if applicable):

Result of Medical Consult /Rare Blood Consult (if applicable):

Donation Numbers of Acceptable Units (if applicable):

To be filled: Check if Rare: ☐ Amount (_____): Number ABO/Rh: _____ PROGESA Order #: _____

CBS Comments: ☐ Donor Testing Demand Request?

Site_____	Fax _____	Phone_____