Your Hospital's Logo Here

JUSTIFICATION FOR TRANSFUSION

PATIENT IDENTIFICATION

PACKED CELLS

Hgb: _____ Hct: _____

- ☐ ACUTE BLOOD LOSS WITH
  - ☐ > 10% LOSS OF TOTAL VOLUME
  - ☐ HYPOVOLEMIA
  - ☐ SYSTOLIC BLOOD PRESSURE < 90 mm
  - ☐ HCT < 30% OR Hgb < 10g AND FALLING
  - ☐ ESTIMATED BLOOD LOST > 1000 ml
- ☐ CHRONIC SYMPTOMATIC ANEMIA
  - ☐ REFRACTORY TO MEDICAL TREATMENT
  - ☐ PULSE > 100/MIN
  - ☐ RESPIRATORY RATE ≥ 30/MIN
  - ☐ CHEST PAIN, SOB
  - ☐ HGB ≤ 7 gm OR HCT ≤ 21
  - ☐ HEMODIALYSIS AND HGB ≤ 7G OR HCT ≤ 21
  - ☐ PREOP EVALUATION WITH HGB ≤ 8GM OR Hct ≤ 24 AND ANTICIPATED BLOOD LOSS
- ☐ OTHER (SPECIFY): _____

PLATELETS

Platelet Count: _____

- ☐ THROMBOCYTOPENIA ≤ 30,000
- ☐ THROMBOCYTOPENIA ≤ 50,000 W/ BLEEDING OR MAJOR SURGERY
- ☐ PLT. CT. ≤ 100,000 WITH CNS SURGERY
- ☐ PLT. CT. ≤ 100,000 ASSOCIATED W/ MASSIVE TRANSFUSION (≥ 7 UNITS)
- ☐ INTRAOPERATIVE BLEED WITH PLT. CT. ≤ 100,000
- ☐ BLEEDING TIME 2X NORMAL, W/ PETECHIAE & BRUISES
- ☐ PLATELET DYSFUNCTION (DRUG INDUCED OR OTHER WITH BLEEDING TIME 2X NORMAL
- ☐ HYPERCONSUMSUMPTIVE COAGULOPATHY
- ☐ OTHER (SPECIFY): _____

FRESH FROZEN PLASMA

PT: ____ PTT: ____

- ☐ REPLACEMENT OF ISOLATED COAGULATION FACTOR DEFICIENCIES (DOCUMENTED BY FACTOR ASSAYS)
- ☐ REPLACEMENT OF MULTIPLE COAGULATION DEFICIENCIES
  - ☐ MASSIVE TRANSFUSIONS
  - ☐ ACTIVE BLEEDING WITH PT / PTT ≥ 1.5X CONTROL
  - ☐ LIVER DISEASE
  - ☐ DIC
- ☐ ANTITHROMBIN III DEFICIENCY
- ☐ TTP
- ☐ OTHER (SPECIFY): _____

CRYOPRECIPITATE

- ☐ DOCUMENTED FACTOR VIII DEFICIENCY
- ☐ VON WILLIBRAND'S DISEASE
- ☐ DOCUMENTED FIBRINOGEN DEFICIENCY
- ☐ DOCUMENTED FACTOR XIII DEFICIENCY
- ☐ OTHER (SPECIFY): _____

BLOOD BANK ORDER SHEET

DATE: _____ TIME: _____

PATIENT / TRANSFUSION INFORMATION

Diagnosis _____

Surgical Procedure _____

Date / Time Needed _____ STAT _____

Ordering Physician _____ M.D.

Please Print

BLOOD BANK TEST REQUEST

- ☐ BLOOD GROUP
- ☐ ANTIBODY SCREEN
- ☐ TYPE AND SCREEN
- ☐ TYPE AND SCREEN AND CROSSMATCH
- ☐ DIRECT ANTIGLOBULIN TEST (COOMBS)
- ☐ OTHER (SPECIFY)_____

BLOOD PRODUCT REQUESTS

	# UNITS	BLOOD BANK USE ONLY
☐ 1. PACKED CELLS		
☐ 2. FFP		
☐ 3. PLATELETS		
☐ 4. CRYOPRECIPITATE		
☐ 5. OTHER (SPECIFY)		

_____ M.D. _____

ORDERING PHYSICIAN (Signature) NURSE'S SIGNATURE / TITLE:

Date: _____ BB Technician: _____ Specimen ID #: _____

WHITE - Chart **YELLOW - Lab**