	<h1>Bureau of Corrections</h1>	Document Reference Code NBP-WI-005-F098	
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PHILIPPINE NATIONAL BLOOD SERVICES PROGRAM
REGIONAL BLOOD SERVICE NETWORK: REGION IV
NEW BILIBID PRISON HOSPITAL

BLOOD REQUEST FORM

DATE: _____ HOSPITAL: _____
 NAME OF PATIENT: _____ AGE: _____ SEX: _____
SURNAME FIRST NAME MIDDLE NAME
 PHYSICIAN: _____ WARD: _____ ROOM NO: _____ HOSP. NO: _____
 CLINICAL DIAGNOSIS: _____
 PATIENT'S BLOOD TYPE: _____ RH TYPE: _____
 HISTORY OF PREVIOUS TRANSFUSION: _____ WHEN: _____ WHERE: _____
 TYPE OF REQUEST: ROUTINE STAT

CHECK COMPONENT NEEDED AND INDICATION FOR TRANSFUSION:

() WHOLE BLOOD (APPROXIMATE VOLUME 500 ML)


- () WB - 1: ACTIVE BLEEDING WITH AT LEAST OF THE FOLLOWING:
 - A. LOSS OF OVER 15% BLOOD VOLUME
 - B. HGB LESS THAN 9G/DL
 - C. BLOOD PRESSURE DECREASE OVER 20 AND/OR LESS THAN 90 mmHG SYSTOLIC
- () WB - 2: OTHERS: PLS SPECIFY (THIS CODE WILL AUTOMATICALLY TRIGGER A REVIEW OF YOUR INDICATION) _____

() PACKED RBC (APPROXIMATE VOLUME 250 ML)

- () R - 1: HGB LESS THAN 8GM /DL OR HCT LESS THAN 24% (IF NOT DUE TO TREATMENT CAUSE)
- () R - 2: PATIENT'S RECEIVING GENERAL ANESTHESIA IF:
 - A. PREOPERATIVE HGB LESS THAN 6 GM/DL OR HCT LESS THAN 24%
 - B. MAJOR BLOOD LETTING OPERATION AND HGB LESS THAN 10 GM/DL OR HCT LESS THAN 30%
 - C. SIGNS OF HEMODYNAMIC INSTABILITY OR INADEQUATE OXYGEN CARRYING CAPACITY (SYMPTOMATIC ANEMIA)
- () R - 3: SYMPTOMATIC ANEMIA REGARDLESS OF HGB LEVEL (DYSPNEA, SYNCOPE, POSTURAL, HYPOTENSION, TACHYCARDIA, CHEST PAINS, TIA)
- () R - 4: HGB LESS THAN 8 GM/DL OR HCT LESS THAN 24% WITH CONCOMITANT HEMORRHAGE, COPD, CAD, HEMOGLOBINPATHY, SEPSIS
- () R - 5: OTHERS: PLS SPECIFY, (THIS CODE WILL AUTOMATICALLY TRIGGER A REVIEW OF YOUR INDICATION) _____

() WASHED RBC (APPROXIMATE VOLUME 100 ML)

- () WP - 1: HISTORY OF PREVIOUS SEVERE ALLERGIC TRANSFUSION REACTION OR ANAPHYLACTOID REACTION IMMUNOCOMPROMISED PATIENTS
- () WP - 2: TRANSFUSION OR GROUP "O" BLOOD DURING EMERGENCIES WHEN THE SPECIFIC BLOOD IS NOT IMMEDIATELY AVAILABLE
- () WP - 3: PAROXYSMAL, NOCTURNAL HEMOGLOBINURIA
- () WP - 4: OTHERS: PLS SPECIFY, (THIS CODE WILL AUTOMATICALLY TRIGGER A REV REVIEW OF YOUR INDICATION) _____

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NOTE: COMMENTS ON RBC PRODUCTS:

1. DOCUMENTS PRE AND POST TRANSFUSION HGB AND HCT WITHIN 24 HOURS
2. DOSE: ADULTS - GIVE ON A UNIT - TO - UNIT BASIS
REMEMBER, 1 UNIT MAY SUFFICE TO ALLEVIATE SYMPTOMS OF ANEMIA
INFANTS - 10 ML/KG//BW

() PLATELETS (APPROXIMATE VOLUME 50 ML)

- () P - 1: PROPHYLACTIC ADMINISTRATION WITH COUNT $\leq 20,000$ AND NOT DUE TO TTP, ITP, HUS
- () P - 2: ACTIVE BLEEDING WITH COUNTS $\leq 50,000$
- () P - 3: PLATELET COUNT $\leq 50,000$ AND PATIENT TO GO INVASIVE PROEDURE WITHIN 8 HOURS
- () P - 4: PLATELET COUNT $\leq 100,000$ IF SURGERY IS ON CRITICAL AREA (E.G., EYE, BRAIN, ECT)
- () P - 5: MASSIVE TRANSFUSION WITH DIFFUSE MICROVASCULAR BLEEDING AND NO TIME TO OBTAIN PLATELET COUNT
- () P - 6: OTHERS: PLS SPECIFY, (THIS CODE WILL AUTOMATICALLY TRIGGER A REV REVIEW OF YOUR INDICATION) _____

NOTE:

1. DOCUMENT PLATELET COUNT BEFORE (WITHIN 8 HOURS) AND AFTER (WITHIN 1 HOUR) TRANSFUSION
2. 1 UNIT: 10 KG/BW WITH MAXIMUM OF 8 UNITS

() CRYOPRECIPITATE (APPROXIMATE VOLUME 20 ML)

- () C - 1: SIGNIFICANT HYPOFIBRINOGENEMIA (< 100 MG/DL)
- () C - 2: HEMOPHILIA A
- () C - 3: VON WILLERBRAND'S DISEASE OR UREMIC BLEEDING WITH PROLONGED BLEEDING TIME
- () C - 4: OTHERS: PLS SPECIFY, (THIS CODE WILL AUTOMATICALLY TRIGGER A REV REVIEW OF YOUR INDICATION) _____

() FRESH FROZEN PLASMA (APPROXIMATE VOLUME 200 - 250 ML)


- () F - 1: PT OR PTT > 105 TIMES MID - NORMAL RANGE WITHIN 8 HOURS OF TRANSFUSION (PT > 17 SECS. PTT > 47 SECS)
- () F - 2: SPECIFIC FACTOR DEFICIENCIES NOT TREATABLE WITH CRYOPRECIPITATE
- () F - 3: REVERSAL OF CAUMADIN ANTI-COAGULANT IN PATIENT WHO ARE BLEEDING AND NOT TREATABLE WITH VITAMIN K
- () F - 4: TREATMENT OF TTP
- () F - 5: CLINICAL CLAUDULOPATHY ASSOCIATED WITH:
 - A. MASSIVE TRANSFUSION (≥ 200 UNITS OF BLOOD IN 24 HOURS)
 - B. LATE PREGNANCY TERMINATION OR ABRUPTIO PLACENTAE
- () F - 6: OTHERS: PLS SPECIFY, (THIS CODE WILL AUTOMATICALLY TRIGGER A REV REVIEW OF YOUR INDICATION) _____

NOTE:

1. DOCUMENT PT/PTT PRE AND POST - TRANSFUSION WITHIN 4 HOURS
2. DOSE : 10 ML / KG BW OR INITIAL LOADING DOSE OF 15 ML /KG BW CORRECTION OF SIGNIFICANT COAGULOPATHY REQUIRES > 2 UNITS FFP

NO. OF UNITS NEEDED: _____

NO. OF DONORS PROVIDED: _____
 SCREENED _____
 UNSCREENED _____

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TYPE OF CROSSMATCHING:

- SALINE PHASE ONLY
- SALINE, ALBUMIN PHASE ONLY
- SALINE, ALBUMIN, GLOBULINE PHASE

(PLEASE CHECK ACCEPTANCE OF RESPONSIBILITY FORM IF NECESSARY)

OTHERS:

REMARKS:

 REQUESTING PHYSICIAN
 (SIGNATURE OVER PRINTED NAME)

RECEIVED BY: _____ DATE AND TIME: _____
 EXTRACTED BY: _____ DATE AND TIME: _____