NewYork-Presbyterian

45171

Downtime / Manual
BLOOD PRODUCT ORDER FORM

Patient Name: _____

MRN: _____

Account Number: _____

Transfusion Medicine
NYP Brooklyn Methodist Hospital
506 6th Street 2ND Floor
Room 2008
Brooklyn, New York 11215

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Date: ____/____/_____ Time: _____AM/PM	Primary Diagnosis:	Date of Birth/Age:	Location:
Priority: ☐ **STAT** (available ≤ 1 hour) ☐ **Routine** (available ≤ 4 hours) **Is patient actively bleeding?** ☐Yes ☐No		Patient's Weight: _____kg Pediatrics < 25 Kg, • dosing in mL,	

Red Blood Cells	**Plasma**	**Platelets**	**Cryoprecipitate**
		1 product = 1 apheresis plt	**1 product = 5 units of Cryo**
#_____units/mL (circle one)	#_____units/mL (circle one)	#_____product/mL (circle one)	#_____product/mL (circle one)
Indication required: ☐ Active, ongoing bleeding ☐ Symptomatic anemia (document symptoms): _____ ☐ ECMO Prime ☐ Other (provide justification) _____	**Indication required:** ☐ Bleeding with loss of one blood volume & no labs available ☐ INR > 1.6 for patients with bleeding and/or surgery ☐ Patients receiving plasma exchange with coagulopathy or imminent procedure ☐ Patients treated with L-asparaginase ☐ TTP, HUS ☐ Other (provide justification) _____	**Indication required:** ☐ Bleeding with loss of one blood volume & no labs available ☐ Bleeding with qualitative platelet defect ☐ Platelet count < 10,000/µL ☐ Platelet count < 50,000/µL with minor bleeding/procedure ☐ Platelet count < 100,000/µL with ECMO ☐ Other (specify) _____	**Indication required:** ☐ Abnormal fibrinogen (dysfibrinogenemia) ☐ Acquired hypofibrinogemia < 60 mg/dL ☐ Disseminated Intravascular Coagulation (DIC) ☐ Fibrinogen < 150 mg/dL with bleeding/surgery ☐ Uremic bleeding refractory to DDAVP and dialysis ☐ Other (specify) _____
Special Requirements: ☐ Hemoglobinopathy ☐ Other _____	**Specify Other Special Requirements:** _____	**Specify Other Special Requirements:** _____	**Specify Other Special Requirements:** _____

Other-Patient weight required for all factor requests (enter in allotted space) :_____

- ☐ **Fibrinogen Concentrate:** _____Vial(s) (1000mg/vial)
- ☐ **RhIG-IV** _____International Units
- ☐ **RhIG-IM** _____Vial (s)
- ☐ **Granulocytes** _____Unit (s)

Ordering MD/NP/PA (Required): **Signature:**_____**MD/NP/PA** **Print:** _____	**MD Code/CWID:**	**Call Back # (Required):**
	Deliver to: Blood Bank or Blood Bank Fax: **718-780-3655** **Fax: 718-780-3466**	