Canadian Blood Services
it's in you to give

SOLVENT DETERGENT PLASMA - REQUEST FORM

BOX 1: INFORMATION TO BE PROVIDED BY REQUESTING HOSPITAL

(Send Request to Local Canadian Blood Services Distribution Site)

Requesting Hospital Details:

Hospital Name: _____ Request Date: _____

Hospital Contact Person: _____ Contact # *(cell, pager, etc.)*: _____

Ordering Physician: _____ Contact # *(cell, pager, etc.)*: _____

Patient Information:

Patient Age Range: < 20 yrs ☐ 20 – 45 yrs ☐ 46 – 65 yrs ☐ >65 yrs ☐

Patient Hospital ID# *(optional)*: _____ Sex: Female ☐ Male ☐

Height: _____ Weight (kg): _____ Blood Group: _____

Clinical Diagnosis:

Thrombotic Thrombocytopenic Purpura ☐ Acquired ☐ / Congenital ☐

Hemolytic Uremic syndrome ☐

Clotting Factor Deficiency ☐ Specify: _____ Is a licensed factor concentrate available? Yes ☐ No ☐

Other *(specify)*: _____

Additional Supporting Information:

Patient has experienced an allergic reaction to plasma Yes ☐ No ☐

Patient has a pre-existing lung disorder Yes ☐ No ☐

Patient is group AB and needs plasma, but a blood group compatible product is unavailable Yes ☐ No ☐

Comments, including additional justification for use: _____

Proposed Treatment: *(for Canadian Blood Services inventory planning only)*

Blood Group *(if different than above)*: _____ Start Date of Treatment: _____

Estimated Amount Required per Treatment: _____ Frequency of Treatment: _____

(for multiple treatments include start date and expected frequency of treatment, e.g. using 5 to 8 per day starting on June 1)

Estimate Length of Treatment*****: _____

E.g.: Amount: 4 units Frequency: Every Week Length of Treatment: for 52 weeks

**Requested length of treatment cannot be greater than 12 months. All approvals will expire 12 months from the date of review noted in Box 2.*

Note: *If any significant changes are made to the proposed length or amount of treatment, please contact your local CBS distribution site.*

Note: *The Plasma Protein Order Form can be sent at the same time.*

BOX 2: CANADIAN BLOOD SERVICES USE ONLY: PHYSICIAN DECISION

(Signature and Name of Physician only required for Clinical Diagnosis "Other" in Box 1)

Product Request Classification:

Meets criteria for use: Yes *(Approved)* ☐ No *(Rejected)* ☐

If rejected give details: _____

Name of Physician *(print name)* or N/A ☐ : _____

Signature of Physician *or* N/A ☐: _____ Review Date: _____

All approvals will expire 12 months from the date of review noted above

BOX 3: CANADIAN BLOOD SERVICES PRODUCT DISTRIBUTION USE ONLY

Comments****:** _____

_____

Date and Time Request Received: _____ **Contract Number:** _____

Estimated Total Quantity: _____ **Expiry Date*******:** _____

E.g.: How to calculate **Estimated Total Quantity**: 4 units X **Frequency**: Every week X **Length of Treatment**: 52 weeks = 208

**For verbal decision record: Name of Physician providing the decision, approved or rejected, Indicate received verbally, initials, date and time.

***All approvals/Contracts will expire 12 months from the date of review noted in **Box 2** above.