Canadian Blood Services
Edmonton Centre Fax: (780) 431 - 8779

**TMS REQUEST FOR BLOOD COMPONENTS**

Hospital:_____ City/Town: _____ Date:_____ Time:_____ Faxed by:_____

□ STAT (immediately) □ ASAP (within one hour) □ ROUTINE (next run) □ OTHER:_____

Mode of Transportation: _____

## RED BLOOD CELLS

| Rh POS | REQUEST |
|---|---|
| O | |
| A | |
| B | |
| AB | |

| Rh NEG | REQUEST |
|---|---|
| O | |
| A | |
| B | |
| AB | |

| SPECIAL REQUESTS | | |
|---|---|---|
| □ Irradiated<br>□ Anti - CMV Neg<br>□ Phenotyped<br>□ Washed | Patient | |
| | Group | |
| | # Units | |
| | Indication | |

## PLASMA COMPONENTS

| Cryo-supernatant PLASMA | REQUEST |
|---|---|
| O | |
| A | |
| B | |
| AB | |

| FP/FFP | REQUEST |
|---|---|
| O | |
| A | |
| B | |
| AB | |

| CRYO | REQUEST |
|---|---|
| O | |
| A | |
| B | |
| AB | |

| | GROUP | REQUEST |
|---|---|---|
| AFFP | | |
| FP Divided | | |

NOTE: Complete section below if thawed components are required.

## PLATELET COMPONENTS and THAWED PLASMA COMPONENTS

| COMPONENT | REQUEST | PATIENT: | DOB: | SEX: |
|---|---|---|---|---|
| **PLATELET – Standard Adult Dose** | | **HOSPITAL #:** | **PHN:** | |
| **PLATELET- Child Dose** | **mL** | **ORDERING PHYSICIAN:** | | |
| **PLATELET (Apheresis)** | | **CLINICAL INDICATION:** | | |
| **Special Attributes:** □ **Anti-CMV Neg** □ **Irradiated** | | **Date/Time to be transfused:** | | |
| **THAWED** _____ | | **COMMENTS:** | | |

| ORDER FILLED BY: (Initial required only when issuing manually) | RED BLOOD CELLS | PLATELETS | PLASMA COMPONENTS |
|---|---|---|---|
| | | | |

## NOTIFICATION OF SPECIMENS FOR TESTING (Crossmatch, Referral)

| PATIENT NAME/PHN | TEST REQUESTED | UNITS REQUIRED | SAMPLES ARRIVING IN EDMONTON | | | |
|---|---|---|---|---|---|---|
| | | | Date | Time | Mode of Transport | Waybill # |
| Name: | | | | | | |
| **PHN:** | | | | | | **Comments:** |
| **BLOOD TO BE SHIPPED TO HOSPITAL** | Date: | | Time: | | | |
| **PREFERRED MODE OF TRANSPORT TO HOSPITAL** | | | | | | |