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BPR Control Number:

PHILIPPINE GENERAL HOSPITAL
The National University Hospital
University of the Philippines Manila
Department of Laboratories
PGH Blood Bank
Taft Avenue, Manila

PHIC-Accredited Health Care Provider
ISO 9001 Certified

BLOOD PRODUCT REQUISITION FORM

(to be filled up by a physician and submitted upon blood request)

Date: _____
Time: _____

Patient's Name: _____ Age/Sex: _____ Birthdate: _____ Weight: _____
Case Number:_____ Location:_____ Attending MD& Contact. no:_____
Diagnosis:_____

Patient's Blood Type:_____Rh_____Date done_____
Most recent transfusion?____ units of ____ on_____ at_____.
Previous Transfusion Reactions? ☐Yes (specify) _____☐No.

Date of Lab Results:_____
Hb ____ Hct _____PC_____
PT_____ INR_____ Activity___
PTT____ Control_____
TB_____ DB_____ IB_____

With Donor ☐No ☐Yes (please attach donor slips).
Type of Request: ☐Emergency ☐Non-Emergency (Date Needed:_____)

☐**Packed Red Blood Cells (PRBC)** ☐Leukoreduced
___Units **OR** ____Aliquot/s of ____cc each
- ☐ Symptomatic Anemia (specify): _____
- ☐ Ongoing Bleed (volume & timeframe): _____
- ☐ Neonates: Hb< 130 g/L & assisted ventilation
- ☐ For procedure (specify):_____
- ☐ Others:_____

☐**Platelet Concentrate (PC)** ☐Leukoreduced
___Units
- ☐ Massive Transfusion
- ☐ Active Bleeding (specify):_____
- ☐ Qualitative Defect (specify): _____
- ☐ For procedure (specify):_____
- ☐ Others:_____

☐**Fresh Frozen Plasma (FFP)**
___Units
- ☐ PT > 17 secs ☐PTT > 47 secs
- ☐ Active Bleeding (specify):_____
- ☐ TTP; Factor Deficiency
- ☐ Warfarin coagulopathy
- ☐ Other clinical coagulopathy (specify):___
- ☐ Massive or exchange transfusion
- ☐ Others:_____

☐**Cryoprecipitate**
___Units
- ☐ Hypofibrinogenemia
- ☐ Hemophilia A
- ☐ von Willebrand Disease
- ☐ Disseminated Intravascular Coagulation
- ☐ Uremic bleeding with prolonged bleeding time
- ☐ Others:_____

☐**Cryosupernate**
___Units
- ☐ Hemophilia B or TTP.
- ☐ Factor II, VII, or X deficiency
- ☐ Warfarin anticoagulation
- ☐ Liver disease
- ☐ Others: _____

☐**Whole Blood** ☐Fresh (<5 days of storage)
___Units
- ☐ Active bleeding with >25% blood loss, or with symptoms (specify):_____
- ☐ Exchange Transfusion - Hyperbilirubinemia <1 wk old or with illness (specify): _____
- ☐ Other:_____

Accomplished by:_____
Signature over printed name of RIC/MD

Favorably Endorsed:_____
Chief Resident/Senior Resident

Year level:_____

Received by:_____
Signature over printed name of RMT

Date/Time Received:_____