BLOOD MANAGEMENT SERVICE

Request for Consultation/Referral

Phone: 204-926-8006 Fax: 204-940-3255

Date of Referral: D D M M M Y Y Y Y

MRN
Client Surname
Given Name
Date of Birth
Gender
PHIN

PLEASE ATTACH MOST RECENT CBC, IRON STUDIES (FERRITIN, IRON, TIBC), MEDICAL HISTORY, MEDICATION, & RELEVANT DOCUMENTATION IN ORDER TO EXPEDITE CONSULT

REASON FOR REFERRAL

☐ Non-consent for transfusion	☐ Staged or multiple surgeries
☐ High blood loss surgery	☐ Low body weight (less than 60 kg)
☐ History of anemia – current Hgb:	☐ Difficult cross-match
☐ Other *(specify)*:	

PATIENT INFORMATION

Is the patient aware of the referral to Blood Management Service? ☐ Yes ☐ No

Mailing Address:			Home Phone: - -
City:	Province:		Work Phone: - -
Postal Code:	Height: ☐ centimetres ☐ feet/inches	Weight: ☐ kilograms ☐ pounds	Cell Phone: - -

SURGICAL INFORMATION

Procedure:

Facility:

Surgeon:

Surgery Date: D D M M M Y Y Y Y	Expected Blood Loss:

PLEASE FILL OUT BOTTOM SECTIONS OR ATTACH DOCUMENT

PAST MEDICAL HISTORY	MEDICATIONS
	ALLERGIES

REFERRING HEALTH CARE PROVIDER

Signature:	Printed Name and Designation:
Address:	Phone: - -
	Fax: - -