

MR#:
 Name of Patient: _____
 Date of Birth: _____
 Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
 MEDICAL CENTER
 SACRAMENTO, CALIFORNIA
 Department of Pathology and Laboratory Medicine,
 Transfusion Services
 2315 Stockton Boulevard
 Sacramento, California 95817

**SPECIAL BLOOD BANK REQUISITION
 FOR EXSANGUINATION**

Call Transfusion Services 4-2585 to Activate the MTG

(Please also call to discontinue the MTG)

Request for MTG Blood Products (Massive Transfusion Guideline)

| Check one box √ | Age (Yr) | Wt (Kg) | Patient approx. blood volume (mL) | Blood Products Provided "O" RBC (units may not be crossmatched at time of issue; crossmatch will be completed once specimen is received). | MTG approx volume (mL) |
|--------------------|----------|-----------------|-----------------------------------|--|------------------------|
| | 0-11 | Less than 35 | 270-2450 | 3 RBC adult, 1 Jumbo FFP*, 1 Plateletpheresis | 1500 |
| | 12-Adult | Greater than 35 | Greater than 2451 | 6 RBC adult, 2 Jumbo FFP*, 1 Plateletpheresis | 2800 |

*Plasma may be dispensed in equivalent volume

**** OR ****

Request for uncrossmatched "O" RBC: _____ # units.
 Request for uncrossmatched "AB" Plasma: _____ # units.

Units may not be crossmatched at time of issue; crossmatch will be completed once specimen is received.

It is my clinical judgment that the above named patient is in urgent need of blood.

Physician: _____, M.D. _____
 Print Name Physician Signature PI # Date/Time

Dispensing Record & Blood Component Donor Numbers:

Inspected for color, appearance, expiration date, clots, and hemolysis by: (Initials) _____

Receiving RN or Designee (Signature): _____