

DATA P1021479

Imprimé au Canada



Blood Products
Stem Cells
Human Tissues

Physician's request for autologous transfusion

Family name : _____

Given name(s): _____

Date of birth: _____/Day _____/Month _____/Year

Sex: Male Female

Telephone number: Home: _____

Business: _____

Address: _____

Identification number (if applicable): _____

Type of surgery: _____

Surgery date: _____

Hospital: _____

City: _____

Required number of donations: _____

Products required: Red blood cells

Other (specify): _____

Requesting physician: _____

Address: _____ Telephone number: _____

Surgeon's name if not requesting physician: _____

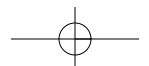
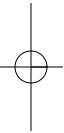
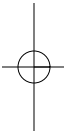


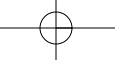
(Impression of medicare card)

Date d'entrée en vigueur : 11-10-2010

SCP-ENR-149.2
Version 5

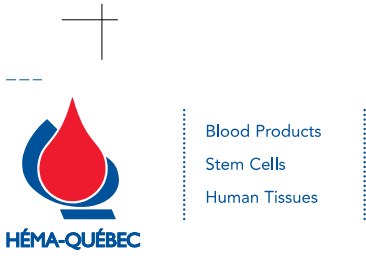
HOSPITAL BLOOD BANK COPY





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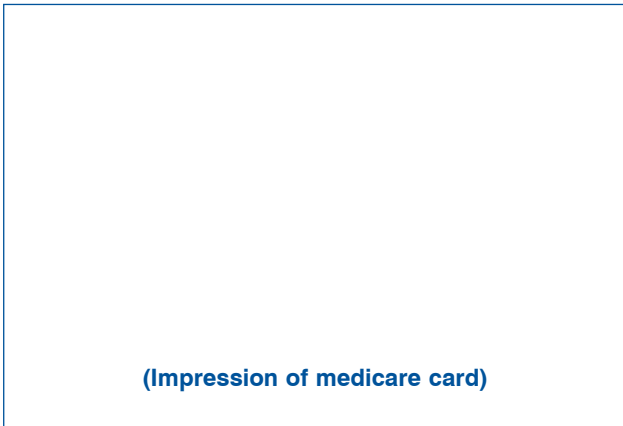
Other (specify): _____

Requesting physician: _____

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Surgeon's name if not requesting physician: _____

Date d'entrée en vigueur : 11-10-2010



(Impression of medicare card)

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> **This section must be completed and signed by the requesting physician**

Medical history (physician's comments):

I have prescribed an iron supplement for this patient: Yes No

If the woman has undergone a mastectomy, do you authorize that the blood sample be taken on the same side as the gangliectomy when there is no other venous access on the arm opposite to the mastectomy? Yes No

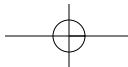
Physician's signature _____

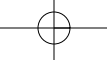
Date _____

Date d'entrée en vigueur : 11-10-2010
(SAP 51221-5)

SCP-ENR-149.2
Version 5

REQUESTING PHYSICIAN'S COPY





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Date _____

Date d'entrée en vigueur : 11-10-2010
(SAP 51221-5)

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HÉMA-QUÉBEC'S COPY

