**Community Hospital Day Transfusions Booking Form**

|  |  |
| --- | --- |
| **Section 1 Patient details, treatment requested, rational and date requested** | |
| **Patient name:** | **Date of birth:** |
| **NHS number:** | **Referring clinician:** |
| **Area (eg Town/Exmouth):** | **Name of GP practice & GP:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Treatment /Transfusion requested :** | | | | | | | **Rationale for treatment:** | | | | | | | | | |
| **Patient Weight: Patient Height:** | | | | | | | **Patients verbal consent for above treatment obtained: Please circle Yes / No** | | | | | | | | | |
| **Location preference: Please tick** | | | | | | | | | | | | | | | | |
| **Sidmouth** |  | | **Tiverton** | |  | | Wynard Ambulatory Unit (default if no capacity for required time or if patient because of locality would prefer their transfusion at the RDE contact 01392 408609) | | | | | | | | | |
| **Date and time preference:** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Section 2 Only complete this section if a Red Cell Blood Transfusion** Please discuss risks/benefits with patient | | | | | | | | | | | | | | | | |
| **Indication for packed red cell transfusion:**  **Please tick** | | | | | | | | **Special requirements?** | | | | | **Confirmation that risks of transfusion were explained:** | | | |
| Bleeding | | | | | |  | | Irradiated | | |  | | Human Error | | |  |
| Symptomatic Anaemia | | | | | |  | | CMV Negative | | |  | | Circulatory Overload | | |  |
| Top up transfusion for chronic anaemia or prior to surgery | | | | | |  | | HLA selected | | |  | | Adverse Immune Responses | | |  |
| Transfusion Transmitted Infection | | |
| Anaemia in patient under care of haematology, oncology, radiotherapy or renal physicians | | | | | |  | | **Pre-Transfusion Hb** …………….........g/l.  **Date of sample** …………………………………. | | | | | | | | |
| Other…….. | | | | | | | | **Target Hb** ……………………...g/l | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Section 3 Only complete this section if an Iron Infusion** Please discuss risks/benefits with patient | | | | | | | | | | | | | | | | |
| History/Source of Iron Deficiency: | | | |  | | | | | | | | **Hb** | |  | **Date of sample** | |
| Previous Iron infusions (date): | | | |  | | | | | | | | **Ferritin** | |  |
| Height | |  | | Weight (within last 3 months) | | | | | |  | | **MCV** | |  |
| Currently taking oral Iron | | | | Yes/No | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | |
| **Section 4** | | | | | | | | | | | | | | | | |
| Further details of other treatments requested: (eg IV treatment/IVIg/venesection) | | | | | | | | | | | | | | | | |
| **Print name** | | | | | | | | | **Date** | | | | | | | |