PERIOPERATIVE BLOOD MANAGEMENT REFERRAL FORM

Please forward completed form to PeriopBloodManagement@nshealth.ca

Patient Name: _____

Patient DOB: _____ (YYYY/MON/DD)

HCN: _____

or

MRN: _____

Patient Weight: _____ kg Patient Height: _____ cm

Referral Date: _____ (YYYY/MON/DD)

Referring Location: _____ Contact Information: _____

Surgical Service: _____ Surgery Date: _____ (YYYY/MON/DD)

Surgeon: _____

Procedure: _____

Surgery Site: ❑ Central Zone: ❑ HI ❑ VG ❑ DGH ❑ Other: _____

❑ Northern Zone: Location: _____

❑ Eastern Zone: Location: _____

❑ Western Zone: Location: _____

Consult Type (mark all that apply):

❑ Anemia ❑ Low Body Weight ❑ Greater than 500 mL EBL ❑ Coagulopathy ❑ Revision ❑ Staged Procedure

❑ Refusal - ❑ Personal ❑ Religious

Additional Information:

_____

_____

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