Blood Products
Stem Cells
Human Tissues

HÉMA-QUÉBEC

GRANULOCYTES APHERESIS REQUEST

IMPORTANT: This form "ENR-03946" must be completed by the Hospital. In addition, form "ENR-03947 - Request and Release of Products with Incomplete Analyses" must also be completed.

PATIENT INFORMATION (RECIPIENT)	Name : _____	First name : _____
	Date of birth (dd/mm/yyyy) :_____	Gender : M ☐ F ☐
	Blood type: ☐ O ☐ A ☐ B ☐ AB Rh : ____	
HOSPITAL INFORMATION	Hospital name : _____	
	Customer no. : _____	Requested by : _____
	Name of requesting physician: _____ Blood Bank Medical Director: _____ Phone number of the Blood Bank Medical Director: _____	
DIAGNOSIS and indications for transfusion : _____ _____ _____	Start date (dd/mm/yyyy) : _____ Requested quantity : _____ Frequency : _____ Treatment duration: _____ (number of days)	

GRANULOCYTES BY APHERESIS: IRRADIATED YES ☐ NO ☐ Anti-CMV NEG. YES ☐ NO ☐

ABO group selection chart for granulocyte units *(for information)*

Recipient's group	1st choice	2nd choice
O	O	
A	A	
B	B	
AB	AB	A*

* : Will be considered if group AB granulocytes are not available. The hospital will be contacted beforehand to inform and obtain authorization.

Additional comments (if required): _____
_____
_____

FAX TO CUSTOMER SERVICE-HOSPITALS (514) 904-2522 / 1 (866) 811- 9465
TO REACH CUSTOMER SERVICE-HOSPITALS, CALL 514 832-5000/1, (888) 666-4362, EXT. 6909
OR SEND AN EMAIL: SAC.HOPITAUX@HEMA-QUEBEC.QC.CA