Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

BLOOD MANAGEMENT SERVICE

Request for Consultation/Referral

Tel: 204|787.1277

Fax: 204|787.4529

MRN #: _____

Client Surname: _____

Given Name: _____

Date of Birth: _____

Gender: _____

PHIN: _____

Date for Referral: | | | | (DD MMM YYYY)

****PLEASE ATTACH MOST RECENT CBC, IRON STUDIES (FERRITIN, IRON, TIBC), MEDICAL HISTORY, MEDICATION, & RELEVANT DOCUMENTATION IN ORDER TO EXPEDITE CONSULT ****

REASON FOR REFERRAL*

☐ Non-consent for transfusion	☐ Staged or multiple surgeries
☐ High blood loss surgery	☐ Low body weight (<60kg)
☐ History of anemia: current hgb: ____	☐ Placenta Abnormalities, specify:
☐ Difficult cross-match	☐ Other, specify:

PATIENT INFORMATION

Is the patient aware of the referral to BMS? ☐ Yes ☐ No

Does patient consent to BMS leaving a phone message? ☐ Yes ☐ No

Mailing Address:

City:	Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:
Ht: _____cm/feet	Wt: _____lbs/kg	

SURGICAL INFORMATION

Procedure:			
Facility:			
Surgeon:			
O.R. Date:		Expected Blood Loss:	

PLEASE FILL OUT BOTTOM SECTIONS OR ATTACH DOCUMENT

PAST MEDICAL HISTORY:	MEDICATIONS:
	ALLERGIES:

REFFERING HEALTH CARE PROVIDER

Name : _____ **Designation:** _____

Address: _____ **Phone Number:** (____) _____

Fax Number: (____) _____