



Provincial Blood  
Coordinating Program



## octaplex® Request Form

Patient Name: \_\_\_\_\_

Health Care #: \_\_\_\_\_

Requesting Physician Name: \_\_\_\_\_

Indication for Use: \_\_\_\_\_

Amount Ordered: \_\_\_\_\_ (Available in 500 IU F IX activity/ 20 mL vial)

Lot # Issued: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Pre-Treatment INR values: \_\_\_\_\_

Post-Treatment INR values: \_\_\_\_\_  
(sample must be drawn within 15 minutes of administration)

Clinical Outcomes: must be completed within 24 hours of treatment

◆ Effect of treatment on bleeding : (describe outcome)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

◆ Thrombotic complications including, but not limited to:

- Myocardial infarction       Yes  No
- Cerebro-vascular accident     Yes  No
- Deep Vein Thrombosis         Yes  No
- Pulmonary edema               Yes  No
- Other: (describe) \_\_\_\_\_

Post Treatment Evaluation: must be completed within 30 days of treatment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Print name)

Physician Signature: \_\_\_\_\_