

Platelet Audit Data Entry Form

Institutional Questions (answer and to be entered into etools once)

A. Hospital Name – will automatically appear upon log in

B. Does your institution routinely stock PLTs? Yes No

C. Does your institution have PLT transfusion guidelines? Yes No

If yes is answered, does your institution use pre-printed platelet transfusion order set forms based on your institutional guidelines? Yes No Not sure

D. Does your institution use computerized physician order entry (CPOE) for transfusion orders? Yes No

If yes is answered, does the CPOE have transfusion decision support for platelet orders? Yes No

E. Do Technologists perform prospective screening of orders based on pre-transfusion platelet counts? Yes No

If yes is answered, how often are platelet counts checked?

Every order Sometimes During platelet shortages only From designated patient care areas only Other (please specify) _____

F. Does your institution perform retrospective/audit review for PLT orders? Yes No

G. Does your institution provide ABO specific PLTs? Only give group specific If available

H. Does your institution perform titration testing of anti-A/anti-B on group O platelets issued to non-group O recipients? Yes No

I. Does your institution volume reduce for ABO plasma incompatibility? Yes No

PLT Manual Audit Sheet

For site records only- please enter all records electronically into PLT audit tool.

Patient Demographics

Patient Sex: Male Female

Patient age: _____ years/months (select either years/months/days)

Is there a recent (within 1 week) pre-transfusion PLT count on this patient? Yes No

If yes please enter Platelet count _____

Date and Time _____

Is the patient on an anticoagulant? Yes No Unknown

If yes, please select Heparin Warfarin Dabigatran Apixaban Rivaroxaban

Other (please specify) _____

Is the patient currently on any anti-platelet agents? Yes No Unknown

If yes, please select Aspirin Clopidogrel (Plavix) Dipyridamole

Other (please specify) _____

Transfusion Order

Enter date PLT order received in Transfusion Medicine Laboratory (TML) _____

Number of PLT doses ordered: _____

Number of PLT doses transfused: _____

If number of PLT doses ordered differs from PLT doses transfused, why was the number of doses not the same? (only to be answered if number of PLT doses ordered does not match PLT doses transfused)

Order altered due to technologist screening

Order altered following TML physician consult

No longer required by ordering physician

Platelets not available

Other (please specify) _____

Date and Time first platelet dose was issued _____

What is the specialty of the patient's "Most Responsible Physician (MRP)? (please select one)

<input type="checkbox"/> Pediatrics Select sub-specialty <input type="checkbox"/> Anesthesia <input type="checkbox"/> Emergency <input type="checkbox"/> Hospitalist <input type="checkbox"/> Neonatology <input type="checkbox"/> Gynecology <input type="checkbox"/> Surgery <input type="checkbox"/> Internal medicine <input type="checkbox"/> Other	<input type="checkbox"/> Internal Medicine Select sub-specialty <input type="checkbox"/> Cardiology <input type="checkbox"/> Critical care medicine <input type="checkbox"/> Gastroenterology <input type="checkbox"/> General <input type="checkbox"/> Hematology <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Oncology <input type="checkbox"/> Respiriology <input type="checkbox"/> Other	<input type="checkbox"/> Surgery Select sub-specialty <input type="checkbox"/> Cardiac surgery <input type="checkbox"/> Surgery(CVS) <input type="checkbox"/> Surgery(non-cardiac, non-neuro) <input type="checkbox"/> Surgery(neuro-spinal) <input type="checkbox"/> Ear,Nose,Throat (ENT) <input type="checkbox"/> General surgery <input type="checkbox"/> Gynecology <input type="checkbox"/> Orthopedic surgery <input type="checkbox"/> Urology <input type="checkbox"/> Vascular surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Other	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Emergency
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Gynecology	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Obstetrics
<input type="checkbox"/> Radiology	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (please specify) _____		

To which location was the PLT issued?

<input type="checkbox"/> Outpatient clinic-Hematology	<input type="checkbox"/> Outpatient clinic-Oncology	<input type="checkbox"/> Outpatient clinic-Other	<input type="checkbox"/> Emergency	<input type="checkbox"/> Diagnostic Imaging
<input type="checkbox"/> Inpatient ICU (include any ICU such as CCU, CVICU, Neuro ICU)	<input type="checkbox"/> Operating room (including Recovery room)	<input type="checkbox"/> Inpatient-Other	<input type="checkbox"/> Other (please specify) _____	

Transfusion Indications

Transfusion Indication: Select only one:

- Currently Bleeding (Therapeutic)
- Prophylactic (non-bleeding, no procedure)
- Prophylactic (before invasive procedure)

If you selected Currently Bleeding (Therapeutic) above:

What is the patient's bleeding status? Major Bleed Moderate Bleed Minor Bleed

If you selected Prophylactic (non-bleeding, no procedure), move to Other Specific transfusion indications section below.

If you selected Prophylactic (before invasive procedure)

Select the invasive procedure:

- Liver Biopsy
- Kidney Biopsy
- Central Venous Catheter Placement
- Nephrostomy tube placement
- Trans hepatic Biliary Tube Placement
- Lumbar puncture (LP)
- Epidural/spinal anesthesia
- Thoracentesis
- Paracentesis

- Endoscopy
- Bronchoscopy
- Angiography
- Venography
- Cardiac surgery (cardiopulmonary bypass)
- Neurosurgery
- Neuro-spinal surgery
- Surgery other
- Other (please specify) _____

Other Specific transfusion indications, check all that apply

<input type="checkbox"/> Trauma/Injury	<input type="checkbox"/> Recent Bleed (within 48 hours)	<input type="checkbox"/> Post surgery	<input type="checkbox"/> Immune thrombocytopenic purpura	<input type="checkbox"/> Chemotherapy induced thrombocytopenia
<input type="checkbox"/> Thrombocytopenia for reason other than chemotherapy	<input type="checkbox"/> History of intracranial hemorrhage(ICH) in last 28 days	<input type="checkbox"/> History of neurological procedure in last 28 days	<input type="checkbox"/> History of platelet dysfunction or coagulopathy	<input type="checkbox"/> Other, please specify

Was a post-transfusion PLT count done within 1 hr of transfusion? Yes No

If **"Yes"**, provide PLT count _____ x10⁹/L

Date/time of PLT count _____

If **"No"** to question above, was a post-transfusion PLT count done within 24 hrs of transfusion

Yes No

If **"Yes"**, provide PLT count _____ x10⁹/L

Date/time of PLT count _____

You may also list any additional comments/details on this platelet order here, if necessary.