KIRAN HOSPITAL

A Step Towards Healthy Community

Multi Super Speciality Hospital & Research Center

Patient Sticker

Barcode Sticker

BLOOD REQUISITION FORM

Date : _____

Blood Request No. : _____

Type of Request : ☐ Routine ☐ Emergency ☐ Urgent ☐ Immediate

Urgent : Please supply appropriate blood to this patient without compatibility testing on my responsibility.

Immediate : Please supply 'O' Negative Red Cell concentrate without Blood grouping and compatibility testing on my responsibility.

_____

Signature of In-charge Doctor :

Kindly arrange to supply / reserve _____ Blood Group / Rh for our patient

Patient's Name : _____ Gender : Male ☐ Female ☐

Age : _____ IP / UHID No. : _____ Department : _____

Clinical Diagnosis : _____

Name of operative procedure (If Applicable) : _____

Reason for Transfusion : _____ Whether Previously Transfused : Yes ☐ No ☐

Any Previous Transfusion Reaction History : _____

Any Previous Pregnancy with HDFN, still birth, Miscarriage (If Applicable) : _____

Date of Requirement : _____ Time of Requirement : _____

Investigation Values :

HB	Platelet	PT/APTT
gm/dl	cumm	Sec

Required Blood Unit's :

Components	Whole Bood	Packed Cell (RCC / RBC)	Fresh Frozen Plasma (FFP)	Platelet Concentrate (PC)	Cryoprecipitate	Single Donor Platelet (SDP)	Cryo poor Plasma (CPP)	Special / Others
Units								

➡ Informed consent for transfusion of blood has been taken.

➡ I have completely filled up this requisition form and blood sample is collected by me after verification of patient's identity.

_____

Doctor's Sign. with Name & Designation :

For the use of Blood Centre Only

Name of Patient : _____

UHID NO. : _____ **Ward / Bed No. :** _____

Sample Receiving

Date : _____ **Received By :** _____

Time : _____ **BBR No. :** _____

PATIENT'S BLOOD GROUP

CELL GROUPING					Weak D Test	SERUM GROUPING			BLOOD GROUP	
Anti A	Anti B	Anti AB	Anti D1	Anti D2		A Cells	B Cells	O Cells	ABO	Rh(D)

Auto Control : _____ Group done by (Name with Sign.): _____

COMPATIBILITY TEST REPORT

Sr. No.	Unit No. / Segment No.	Expiry Date	Blood Group of Unit	Whole Blood or Type of Component	Cross Match Details				Test performed by sign with name	Issue Detail	
					Method of Cross Match and Result					Date & Time of Issue	Issued by Sign & Name
					Major	Minor	Saline	AHG (Tube / Column Agglutination)			
1											
2											
3											
4											
5											
6											

Result of special tests If performed : _____

Date : _____ **Time :** _____

THINGS TO READ

1. Please take care to identify the patient.
2. Please furnish all the details mentioned in Requisition form, otherwise it will be not accepted.
3. Please send at least 2 ml blood in EDTA and 3 ml blood in Plain bulb / Vacutainer with proper labelling which should include Full name of Patient, Ward / Unit and Registration No, date and time of collection of sample & sign of phlebotomist. Incompletely labelled samples will not be accepted.
4. Requisition form and sample with discrepancy are unacceptable.
5. For pediatrics patients (age < 6 months) , please send mother's sample also.
6. Request for demand of planned operation will be accepted between 9:00 am to 5:00 pm only. Before 9:00 am & after 5:00 pm and on Sunday - only emergency request will be accepted.
7. For any emergency, mention the cause of it and be in contact with Blood Bank.
8. As far as possible use blood components only.