A Step Towards Healthy Community

SAMAST PATIDAR AAROGYA TRUST

KIRAN HOSPITAL

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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 :

KHRC/IPD/FORM/062

[For the use of Blood Bank 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.

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