BLOOD BANK

(Regional Blood Transfusion Center)

Mahatma Gandhi Medical College and Hospital

RIICO INSTITUTIONAL AREA, SITAPURA, TONK ROAD, JAIPUR - 302 022
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BB-2017-0091

Blood Requisition form for Reservation / Issue of blood /Blood Components

Licence No. : RAJ 2030

NOTE : DELAY IN MEETING REQUEST IS LIKELY TO OCCUR UNLESS ALL QUESTIONS ON THIS FORM ARE COMPLETELY ANSWERED. GIVE AT LEAST 24 HOURS NOTICE WHEN TRANSFUSIONS ARE PLANNED.

PATIENT INFORMATION

Patient Name :	Age :	Gender :
Registration No. :	Ward:	Bed:
Father / Husband Name :		
Name of the Hospital :	Phone:	
Name of Consultant :	Phone:	

CLINICAL INFORMATION (Fill by Clinician / Resident Doctor / Nurse)

Clinical History :	Hb gm/dl	Platelet Count
Diagnosis	WBC Count :	PT & APTT
Reason for Transfusion :		
History of Previous Transfusion ☐ Yes ☐ No	Blood Group (if Known) :	
In case of female (Obstetric history)	Incase of child <4 month mother blood group :	

BLOOD COMPONENT REQUESTED

S. No.	Component Name		No. of Units Requested	S. No.	Component Name		No. of Units Requested
1.	Packed Red Blood Cell	☐	..... Units	4.	Cryoprecipitate	☐	..... Units
2.	Platelet Concentrate	☐	..... Units	5.	Whole Blood	☐	..... Units
3.	Fresh Frozen Plasma	☐	..... Units	6.	Single Donor Platelet	☐	..... Units

SPECIFIC REQUIREMENT :- **ID NAT TESTED** ☐ **Leucoreduced Product** ☐ **Other** ☐

Required Date :	Required Time :

STAT ☐ (With in 15 Minutes) Urgent ☐ (within 1 hr) Routine ☐ (After 2 hr) Reserved ☐ (Transfusion not needed for next 8 hours but to be reserved)

Certified that the blood samples & details in the Blood Requisition Form are correct. I have explained the necessity of Blood Transfusion procedure and the risk associated with it to the patient / relatives. The informed consent for this has been taken from patient / relative.

If urgently required please specify reason _____

(Non Cross matched group specific) Date :_____ Name & Signature of Doctor / Consultant

To be Completed by person drawing blood specimen

Patient (if conscious) confirms to his and father's name,
If unconscious Relative(s) Staff confirm the identity,
The identity, Reg. No. matches with the medical records and
Requisition form is properly and completely filled.

Date :_____

Sample tube carries the patient's name, reg. No. ward
These match with the medical records.
Phlebotomist has signed the sample tube.

Name & Signature (Sample Collected by)

INSTRUCTIONS FOR SENDING REQUISITION FOR TRANSFUSION

1. All request form for cross matching (Compatibility testing) of routine cases should be sent 4 hours in advance.
2. Send two sample tubes, minimum of 5 ml. whole blood one in EDTA for blood grouping, Ab screening & one in plain vial for cross matching.
3. The blood sample should be labeled properly & correctly) with patient particulars which should match with the requisition form.
4. The Sample tube of the recipient should be signed by the person who collect the sample.
5. In case of urgent transfusion, please indicate the nature of emergency.
6. Always make sure that blood / blood components are arranged before undertaking any major surgery.
7. Blood / Blood components once issued will not be received back in the blood bank.
8. Cross-matched blood will be kept in reserve for said patient only up to 10 a.m. next day or operation / date requirement unless specific request is received.
9. Always persuade the relatives / friends of your patients to donate blood.
10. Please ensure appropriate & rational use of blood bank does not advocate the use of whole blood.
11. In case of neonates please mention the date and time of dispatch of samples earlier sent along with mother sample. Also please discuss in case you speculate repeat transfusion.

FOR BLOOD BANK USE ONLY

REQUEST NO.		Requisition received on date		Received by		

PATIENT'S CELLS				PATIENTS SERUM						
Anti-A	Anti-B	Anti-AB	Anti-D (Rho)	Blood Group	A-Cells	B-Cells	O-Cells	Pt-Cells	Final Blood Group	Done by

ANTIBODY SCREENING RESULT : Negative ☐ Positive ☐ In Case of Positive further work-up

CROSS-MATCH DETAIL :

Component	Date of Collection	Bag No.	Tube No.	Group	Major Cross Match			Minor Cross match	Sign. and Name of Tech.	Cross-match No. Date & Time	Issue No. Date & Time
					Saline R.T.	Coombs 37°C	Albumin 37°C	Saline R.T.			

DONATION DETAIL

DONATION NO.	RECEIPT NO.	RECEIPT CHARGE	DATE & TIME	REMARKS

BLOOD SANCTIONED

Against Replacement	Vouluntry Card ID	Without Replacement (Recommended by)	Against promise of Replacement (APR)

Observation :

Sign. of Technical Manager/Supervisor **Sign. of BBO**