All India Institute of Medical Sciences, Rajkot

Department of Transfusion Medicine

BLOOD STORAGE UNIT

License No. G/BSC/288

Blood Request Form

BG No. _____

1. Please take care to identify the patient.
2. Please furnish all the details mentioned in Requisition form, otherwise it will not be accepted.
3. Please label the blood sample mentioning Name indoor Reg. No., Ward & Name of Unit Doctor.
4. Requisition form and sample with discrepancy are unacceptable.
5. For exchange transfusion please send the mother's sample along with neonatal sample.

Date: _____ Time:_____

Patient's Name: _____

Indoor MRD No. _____ Age _____ Year _____ Months Sex: M / F

Clinical Diagnosis_____

Ward: _____l/C Unit Dr._____

Date & Name of operative procedure (if applicable)_____

1. Haemoglobin _____gm% 2. Platelet count_____/Cumm 3.PT / PTT_____Sec.

4. BP: (SYS / DIA)_____/_____mmHg 5. Urine Output _____

6. HIV: _____ 7.HBsAg: _____ 8. HCV: _____

Blood Group if Known_____

Any previous Transfusion History: Yes / No _____ Any reaction to transfusion; Yes / No_____

Any previous pregnancy with HDN (If applicable)_____

Type of Request:

1. Only Blood Grouping
2. Requirement of WHOLE BLOOD/PCV/FFP/PC

a. Routine Date & Time :_____

b. Planned Date &Time :_____

c. Emergency Date &Time :_____

Demand of WHOLE BLOOD and PCV

Type	No
WHOLE BLOOD	
PCV	
FFP	
PLATELET CONCENTRATE	

INDICATION FOR WHOLE BLOOD/PCV/FFP/PCTRANSFUSION _____

Informed consent for Blood Transfusion has been taken with entry in the ward indoor case paper. I have completely filled up this requisition form and the blood sample is collected by me after verification of the patient's identity.

Doctor's Name:_____ **Sign:**_____ **Designation:**_____

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INSTRUCTION

1. Please read the copy of Blood Storage Unit rules, Provided to your unit.
2. Double-check the Name as the register No. of the patient, both on this form and also on the label affixed to the blood sample sent for testing.
3. Requests for planned transfusion are acceptable only between 9 A.M. to 3 P.M. on Weekdays and 9 AM.to12 noon on half working days the samples should be sent One day in advance. For urgent cases, samples are acceptable at any time.
4. Inform the Blood Storage Unit immediately, if the proposed transfusion is either cancelled or postponed.
5. A separate report of the Blood Grouping and Compatibility testing will be given which must be sent to the Blood Storage Unit, whenever Blood is needed for transfusion.
6. Blood Request forms will be dispatched by Blood Storage Unit at 10 A.M. & 4 P.M. on stipulated days.
7. For emergency demand of Blood, kindly arrange to collect Blood Group reporting form from Blood Storage Unit.
8. Please fill up new Blood Storage Unit Requisition form only after this form is completely filled up. If earlier form is lost inform the Blood Storage Unit.
9. Please do not take the patient for a Surgical Procedure (Operation) before confirmation of Blood units kept ready for the patient.

(FOR USE OF BLOOD Storage Unit ONLY)

Patient's Name: _____MRD. No._____

Dr: _____ Ward: _____

Blood Sample accepted by _____at _____am/ pm. **BG NO.** _____

BLOOD GROUPING REPORT

ABO Group of Patient**:** _____ Rh Group of Patient**:** _____

Examined by: Name: _____ Signature: _____

COMPATIBILITY TEST REPORT

Sr. No.	Date & Time	Donor Blood Bag Number	Group of Donor	Type of Component or whole Blood	Method of Cross matching	Result of Cross matching	Test Performed by Signature with Name	Visual Inspection & Issue Done By	Date & Time of Issue
1									
2									
3									
4									
5									

NAS-No Abnormality Seen

Result of special test if performed: _____

Date: _____ **Time:** _____