Blood Transfusion

Enquiries - Tel 0161 419 5612

Stockport NHS
NHS Foundation Trust

Patient Details (*Indicates mandatory field)

3 unique identifiers required for all blood transfusion tests
NHS Number is compulsory for all blood transfusion tests

Surname*

NHS No.*

Forename*

District No.

D.O.B.*

Sex* M F

Hospital No.

Address

FOR LABORATORY USE ONLY

Checked by* (Sig)

Requesting Doctor* (Signature)

Sample Taken by* (Signature)

Location*

TRANSFUSION REQUESTS

☐ Group & Antibody Screen

☐ **Crossmatch**
Red Cell Units Required ____________

Irradiated Blood Products **YES NO**
CMV Neg Products **YES NO**
(Please delete)

Fresh Frozen Plasma
Units Required ____________

Platelets
Units Required ____________

Date & Time Products Required*

ANTENATAL REQUESTS

EDD: ____________

☐ Booking Group & Antibody Screen

☐ 28 Week Group & Antibody Screen

☐ Group & Antibody Screen (Other)

Routine Antenatal Anti-D
Date Required ____________

Date Requested ____________

Location for Anti-D Delivery

(Approved Locations Only)

CLINICAL DETAILS - All Requests

Please include all relevant clinical information

Patient Pregnant? YES NO *(Please delete)*

Known Antibodies Present? YES NO *(Please delete)*

ADDITIONAL REQUESTS

Sample Time

Sample Date

Sample acceptance policy will be strictly applied

Website: www.nhslabmedservices.co.uk

JB:71778