Blood Transfusion

Enquiries - Tel 0161 419 5612

NHS Stockport NHS Foundation Trust

FOR LABORATORY USE ONLY

Checked by* (Sig)

Requesting Doctor* (Signature)

Sample Taken by* (Signature)

Sample Taken by* (Print Name)

Location*

Contact No.*

Patient Details *(*Indicates mandatory field)*

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

Surname*

Forename*

D.O.B.* Sex* M F

Address

NHS No.*

District No.

Hospital No.

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: labmedservices.stockport.nhs.uk

JB:71778