

A Guide to Completing Pathology Request Forms

Blood Transfusion

NORTH DEVON DISTRICT HOSPITAL PATHOLOGY SERVICE				BLOOD TRANSFUSION REQUEST			
NHS Number (Affix label in shaded area)		Hospital or GUM Number		Please check the patient's I.D.			
425 659 1709							
Surname - Block CAPITALS please		Date of Birth		Gender (please circle)			
JONES-SMITH		290256		M F			
First Name(s) - Block CAPITALS please		Category (please circle)		Request Status (please circle)			
ETHLERED		NHS Private Cat. 2		Emergency Urgent Routine			
Consultant/GP (Name or Code - CAPITALS please)		Ward / Clinic or Surgery* In emergency phone 2297/bleep 043 out of hours					
FARLEY		DAY SURGERY					
Sample: Date		Time (24hr clock)		Sample Taken and Labelled by: Sign and Print Name LEGIBLY here please			
120615		1020		Dr BL Ooods			
*Location of transfusion if different from that given above		Special Requirements (Please circle) CMV Neg Irradiated Neonatal					
REQUESTS. Refer to separate guidance for tube and labelling requirements.							
Red Cells*	Units	Group / Save ONLY	Date / Time Required	1607151115			
Platelets	Units	Ante Natal Screen	State EDD	D D M M Y Y Parity			
FFP	Units	Foetal Leak	State Date / Time of Delivery	D D M M Y Y H H M M			
IVIG	Dose (g)	DAT	Additional Tests / Products:				
Anti D		Group ONLY					
Previous Transfusion? Y / N Date:		Reaction? Y / N		Clinical Reason(s) for Request:			
				PLEASE INDICATE REASON FOR REQUEST			
Pathology Service, Level 1, North Devon District Hospital, Barnstaple EX31 4JB.				Enquiries 01271 (32) 2327 Fax 01271 (32) 2328			

- Three Key Identifiers** must be entered, clearly indicating whom the patient of the sample is from: include both first and last names. (Abbreviated or preferred names are not acceptable). D.O.B. Either the NHS OR EPIC MRN number. Male/Female information is important as computerised systems may assign gender specific reference ranges to results.

NOTE: Sticky labels are permitted on the request form but NOT on blood tubes.

Request forms without the required three key identifiers or with incorrect information will be **REJECTED**. (See specimen acceptance policy for full details)

- Please indicate clearly whom the Requesting Consultant/ GP is.
- The Ward/Clinic is also required.
- It is necessary to include the **date** and **time** the specimen was taken. The person collecting the specimen must print their name (legible writing) and it must be signed.
- Please indicate what test and/or component/product is required.
- Special Requirements must be filled if necessary.
- Date and time required.
- Clinical reason must be provided.