Licence No. : Raj. 2618

ROTARY BLOOD CENTRE, JODHPUR

(Managed by Rotary Blood Bank Sanchalan Samiti)

K. N. Wanchoo Rotary Bhawan, Gaurav Path, Jodhpur - 342003 (Raj.)

Tel. : 0291-2431558, Mob. : 8824789921, ~~0291-2918538~~

Blood Bank Use only

Request Number .....

Date & Time .....

Received By .....

• BLOOD REQUISITION FORM •

1. PATIENT DETAILS :

Patient Name ..... Age ..... Gender ..... Father's/Husband's Name .....

Patient registration number (UHID/IPD No.) ..... Hospital Name .....

Consultant Name & Mob. No. .....Patient's Mobile No. ..... Blood Group .....

2. INDICATIONS FOR TRANSFUSION & RELEVANT HISTORY :

Diagnosis / Indications for Transfusion .....

Hemoglobin ..... Platelet Count ..... PT/APTT ..... History of Transfusion in last 3 months : ☐ Yes ☐ No

Pregnant (Females) in last 3 months ☐ Yes ☐ No ☐ Don't know

History of Stillbirths/HDN/Miscarriages (In case of Females) : ☐ Yes ☐ No ☐ Don't know

RhoGam/Iv Rh immunoglobin given in last 3 months ☐ Yes ☐ No ☐ Don't know

3. BLOOD / BLOOD COMPONENT REQUIRED. (For Urgent/Emergency requirement please Phone BLOOD BANK also)

Please mark ✓ the necessary : **Routine** ☐ **Urgent** ☐ **Emergency** ☐

Blood/Blood Component required	Number of Units required	Date & Time when required
☐ Whole Blood		.....
☐ Red Cells (Packed Red Cells)		.....
☐ FFP		.....
☐ SDP (Aphaeresis)		.....
☐ RDP		.....
☐ Cryoprecipitate		.....

☐ Pediatric Unit (Component and Volume Required) .....

Declaration From Attending Doctor

I shall personally supervise the transfusion. I shall check blood bag for deterioration and shall be responsible for identification of patient before starting transfusion. Informed consent has been taken from patient and relatives.

Name of MO ..... Sign. ..... Hospital Seal

Contact No. ..... Date & Time .....

4. SPECIMEN COLLECTORS DECLARATION : The patients detail on the specimen tube MUST be hand written by the collector.

1. I Certify that the blood specimen accompanying this request was drawn from the patient named above
2. I Established identity of the patient by direct enquiry / enquiry through patient's attendant.
3. The patient's identity so established matched that as given in the patient's hospital records.
4. Immediately upon the blood being drawn, I labeled and signed the specimen at the bed side.

Signature of the collector ..... Name ..... Mobile No. .....

INSTRUCTION FOR HOSPITAL :

1) All requests for cross matching (compatibility testing) of routine cases should be sent 24 hours in advance.
2) In case of urgent transfusion please indicate the nature of urgency.
3) 5 ml. of patient's blood in plain tube and 5 ml. in EDTA VIAL MUST be sent with the requisition form.
4) **SAMPLE WILL NOT BE ACCEPTED IN SYRINGES.**
5) In a new born baby up to 4 months of age, send **MOTHER'S BLOOD SAMPLE** also.
6) The requisition form must be completely filled in all respects.
7) Unlabled, incorrect, incomplete or illeligible labeled specimen or those with discrepancy to the requisition form will not be accepted. Sample label also must be signed.
8) A new blood sample of patient is required for cross matching with every fresh requisition.
9) **Blood or blood components once issued will not be taken back in blood bank.**
10) Requisitions are accepted round the clock.
11) For routine requirement, cross matched blood unit are reserved for 72 hours from the date of cross match and upto 6 hour for urgent requirement. After the specified period, blood unit will be taken back into the inventory and **NO REFUND WILL BE GIVEN.**

INDICATION

COMPONENTS USAGE-AT A GLANCE

Red blood cells (245-400 ml/Unit) 1- Active bleeding with or without hypovolemic shock. 2- Symptomatic chronic anaemia unresponsive to conservative therapy. 3- Hb < 7 gm/dl. 4- Hb < 10 gm/dl in patient who has cardiac pulmonary or neurogenic disease.	**Platelet Concentrate (40-70ml/Unit)** 1- Platelet count < 20,000 / μl 2- Platelet count < 50,000 / μl with active bleeding. 3- Platelet count < 50,000 / μl and surgery / Invasive procedure. 4- Massive blood transfusion. **Note :** 6-8 bags are equal to a single donor apheresis unit.
Fresh Frozen Plasma (>180 ml/Unit) 1- Prothrombin time > one and a half times control. 2- APTT > 55 Sec or > 4 sec of control (Patient for surgery) 3- Massive blood transfusion. 4- Coagulation factor deficiency. 5- Exchange transfusing. 6- Reversal of Warfarin 7- Consumption Coagulopathy	**Cryo precipitate (10-25 ml/Unit)** 1- Haemophilia A 2- Hypofibringenemia 3- Consumption Coagulopathy
WHOLE BLOOD (350/450 ml/Unit) 1- Blood loss > 15% of Blood volume in adults. 10% of blood volume in children. 2- Neonatal exchange transfusion	

For Blood Bank Use Only

Patient Blood Grouping & Serology

DCT ICT

Anti A	Anti B	Anti D	A Cell	B Cell	O Cell	Auto Control	ABO & Rh

Done by : Date & Time : Details of UNITS / COMPONENT AVAILABLE :

X match details

Unit No.	Tube No.	Component	Blood Group	X match Report	X match Done By	X match Date/Time	Reservation status	Issue Date & Time

For Registration Desk use only : 1. No. of Units on replacement : 2. No of Units on Promise of Replacement : 3. No. of Units on Charity / VD Card :

Signature of Councellor / Technician at registration desk