Woodlands Health
National Healthcare Group

Laboratory Medicine and Pathology

BLOOD TRANSFUSION SERVICE REQUEST FORM

Patient's details

Name:
NRIC:
Gender:
Date of birth:
Account number:
Clinic:
Ward:
Bed:

Affix patient's label here

Requesting doctor *(Please use name stamp if possible)*

Name and MCR number:
Phone number:
Department:
Consultant and MCR number:

Laboratory barcode and accession (for laboratory use only)

Clinical information

Recent travel history:	NO / UNKNOWN / YES (specify):
Previous transfusion:	NO / UNKNOWN / YES (specify date):
Known antibodies:	NO / UNKNOWN / YES (specify):
Previous transfusion reaction:	NO / UNKNOWN / YES (specify type of reaction(s)):
Previous pregnancy (last 3 months):	NO / UNKNOWN / YES

Specimen containers *(Tick box(es) and specify number of each)*

□ Pink (EDTA): ___
□ Purple (EDTA): ___
□ Others (specify): ___

Specimen collection date and time

DD/MM/YYYY
HH:MM am/pm

Test request(s)

□ Type and screen

For pre-admission testing (PAT) only:
Date of operation:

Type of operation:

□ ABO grouping and Rh

□ Direct antiglobulin test

□ Others (specify):

VERIFICATION ***(for Type and Screen specimens only)***

I verify that the patient's identity on this form, specimen, and the patient's wristband all match.

Failure to correctly identify the patient may result in a fatal ABO transfusion reaction.

NOTE: Specimen is only valid for 72 hours from time of collection (reserved blood for patient is held until specimen expiry)

Collected by: *(Please use name stamp if possible)*	Signature:	Date:
Counter-checked by:	Signature:	Date:

Other test requests *(Note: specimens with illegible test requests may be rejected or subject to delayed processing)*

Further information

Please refer to the Laboratory Service Guide for information about specific requirements for tests.
For enquiries, please call the Blood Transfusion Service on 63611009.