ALL INDIA INSTITUTE OF MEDICAL SCIENCES, JODHPUR
Department of Transfusion Medicine & Blood Bank

Basni, Industrial Area, Phase-II, Jodhpur-342005

Blood Bank: 0291-2740742 Ext#1436

For Blood Bank use only:

Request Receiving No. .....

Received on .....

Time .....

Signature .....

Crossmatch & Blood Components Release ☐ or Hold ☐

Patient Name ..... Patient ID ..... Age/ Sex ..... Weight .....

Blood Group: ..... Grouping done at AIIMS earlier: Yes ☐ No ☐ If child < 4 mo: Mothers Group is .....

Father/Husband's Name ..... Address & Phone .....

Faculty In charge ..... Department ..... Ward ..... Bed/Room No .....

Clinical Diagnosis ..... Indication for Transfusion .....

Urgency Category: Routine ☐ Urgent ☐ Emergency Release ☐ Patient Category: General ☐ FOC ☐ Other specify.....

Transfusion History ..... Pregnancy History .....

Hb .....gm/dl, Hct .....%, PT/INR ....., APTT ....., Platelet count...../cubic mm, Fibrinogen.....g/dL

Units to be ordered:

PRBC	FFP	RDP	SDAP	CRYO	BUFFY COAT/ GRANULOCYTE	SPECIAL MODIFICATION (if required)		
						☐ Leuko Filtration	☐ Washed PRBC/Platelet	☐ Irradiation
						☐ Pediatric Unit	☐ Reconstituted WB	☐ Other

Blood Required (Date & Time: .....) Sample collected by..... (Date and Time: .....)

PLEASE PASTE PATIENT STICKER HERE
(Mandatory)

Signature of Faculty / Resident

Doctor's Name & Contact No.

INSTRUCTIONS

1. 3 ml patient's blood in EDTA vacutainer purple top, (1ml EDTA microvacutainer is acceptable for **neonates**) must be sent with the Request.
2. In case of newborns upto 4 months, send another tube with mother sample also (label "**Mother of** _____")
3. For release, fill release request and send Insulated box to carry the Component, which will be handed over only to Hospital Staff.

FOR BLOOD BANK USE

Cell Grouping				Serum Grouping				Result ABO/Rh	Indirect Antiglobulin Test (IAT)
Anti-A	Anti-B	Anti-D	Anti-AB	A cell	B cell	O cell	Auto control		

CROSS - MATCH METHOD - (LISS - COOMB'S / IMMEDIATE SPIN)

Blood Component	Unit No.	Unit Date of Expiry	Unit Blood Group	Blood Unit Segment no.	Unit Vol.	Compatible (Yes/No)	Xm by	Issue by	Issue time & date	Patient Location	Component Recv By

BLOOD REQUEST ACKNOWLEDGEMENT RECEIPT

Patient Name _____ **Patient ID** _____ **Ward/Bed No.** _____

Note: This is **ONLY** an **Acknowledgement Receipt** of blood request form. It does not confirm the availability of blood/blood components. For confirmation regarding the availability of blood/blood components, kindly call **ext#1436**.

PLEASE PASTE PATIENT STICKER HERE
(Mandatory)

"This is to be retained in Patient File"

PRBC	FFP	RDP	SDAP	CRYO	BUFFY COAT/ GRANULOCYTE

For Blood Bank use only:

Request Receiving No. .....

Received on .....

Time .....

Signature .....