NZBLOOD Te Ratonga Toto O Aotearoa

Blood Bank Request Form

eTraceline Use Only

Patient:

Family Name			**Place of Surgery / Transfusion**
Given Names			**Date of Surgery / Transfusion**
NHI	**Date of Birth**	**Gender**	
If patient is a neonate please provide mother's details:	Family Name	NHI	**Ward / Hospital**
	Given Names	Date of Birth	
Diagnosis / Indication for transfusion			**Consultant**

History affects validity of the blood sample for the provision of red cells for transfusion – please see over

You must complete all 3 questions – please tick:

Transfused in the last 3 months?	Yes	No	Unknown	
Pregnant in the last 3 months?	Yes	No	Unknown	NA
RhD Ig given in the last 3 months?	Yes	No	Unknown	

Blood Bank Tests: If the request is urgent please phone the Blood Bank

Group & Antibody Screen	Cord Group & DAT	Direct Antiglobulin Test	Other
1st Antenatal Group & Screen	Subsequent Antenatal Group & Screen	Antenatal Antibody Titre	

Component Required:

		Number	Date and Time Required
Red Cells	Adult		
	Neonatal		
Platelets	Adult		
	Neonatal		
FFP	Adult		
	Neonatal		
Cryoprecipitate			
Other Components			

Fractionated Product Required:

	Dose	Date and Time Required
RhD Immunoglobulin	625 IU	
	250 IU	
Prothrombinex-VF		
IVIg* *Requires prior approval		
Albumex 4		
Albumex 20		
Hep. B Immunoglobulin		
Other		

Requester

Signature	**Print Name** (if not the labeller)	**Contact No. / Pager**	**Date**

MANDATORY DECLARATION by Person Collecting the Sample – *Failure to complete may result in sample rejection*

I certify that I collected the sample(s) accompanying this request from the patient named above
I confirmed the identity of this patient by direct enquiry and / or inspection of their wristband
I labelled and signed the sample(s) by hand immediately after collection at the bedside and in the presence of the patient

Collector

Signature Mandatory	**Print Name** (if not in the box above)	**Contact No. / Pager**	**Time**
			Date

Blood Bank Use:

Received	Hx Patient Data No / Yes / Print	2nd Group No / Yes	Previous Tx	Validity	Registered	Pre-test Check	Frozen	Authorised	Date

Comments

Anti -A	Anti -B	Anti -AB	Anti -D		Ctrl	A cells	B cells		I	II	III						Poly	IgG	C3	Ctrl
								IAT												
Group			Date		Initial			RCAS	Date		Initial						DAT	Date		Initial

eTL	1010	3500	1013	3503	3903	3880	5050

Sample Validity Rules:	
Transfused / Pregnant in the last 3 months	72 hours
No / Incomplete history on this form	72 hours
NOT transfused or pregnant in the last 3 months	7 Days
SPECIAL REQUEST ONLY: Patient will not be available for pre-surgery sample **OR** the date of surgery is uncertain or subject to change	21 Days

Family name | **DOB**

Given names | **NHI**

Comments

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Anti -A	Anti -B	Anti -AB	Anti -D		Ctrl	A cells	B cells		I	II	III					Poly	IgG	C3	Ctrl
								IAT											
								CC+											
Group			Date		Initial			RCAS	Date	Initial						DAT	Date	Initial	

eTL	1010	3500	1013	3503	3903	3880	5050	Authorised	Date

Donation No.	Comp.	Group	Expiry		RT	IAT		Date	Initial	Issue	Date	Time	Initial