# NHS Lothian Blood Transfusion Laboratory

Western General Hospital
Telephone No. 0131 537 1912/2417

NHS SCOTLAND

COMPLETE BOXES 1-6 All points with an * must be completed or the sample will not be tested.

SPECIMENS MUST CONFORM TO BSH GUIDELINES. INCORRECTLY LABELLED SAMPLES WILL NOT BE TESTED (SEE REVERSE).

## 1 Patient Details

CHI No.* ☐☐☐☐☐☐☐☐☐☐

Surname* ................................................

Forename* ................................................

DOB* ................/................/................

Gender ☐ Male ☐ Female

Was patient transfused/pregnant within the last 3 months Y N

Is the patient currently pregnant Y N

Post Transplant Y N

Date of Transplant ......../......../...........

Anti-D this pregnancy Y N

Date & Dose Given ......../......../...........

E.D.D ......../......../...........

## 2 Sample Details

Date Sample taken ............/............/...........

Time Sample taken ....................................

The person who signs below is personally responsible for accurate clear labelling at the patient's side.

Signature & Printed Name of person taking sample*

.............................................................................

Requesting Clinician*

.............................................................................

## 3 Diagnosis/Reason For Request

.............................................................................

## 4 Patient Location

Hospital/Surgery Address.......................................

Ward...........................................................................

Contact telephone/bleep no...................................

## 5 Requirements

Group & Save ☐

Kleihauer ☐

Rhesus Programme (Mother or Child) ☐

RCC amount ........................................

Platelets# amount ........................................

FFP# amount ........................................

Cryo# amount ........................................

Anti-D amount ........................................

Other amount ........................................

#Medical clearance may be necessary

**Special Requirements:**

CMV Neg ☐ Irradiated ☐

## 6 Urgency

EXTREME (10-15 mins) Confirm with call ☐

Very Urgent (<1 hour) ☐

Within 3 hours ☐

Same Day ☐

Other (please give date/time) ........................................

**LAB USE ONLY**

**Specimen Details**

Suitable for E/Release Y N

Initials of person authorising ..............................

Transfusion History:

Not Available

Date of most recent Issue ................................

Antibodies ........................................................

2nd sample required Y N

2nd sample requested Y N

**Date and time sample received**

**Sample Tube/Request Form Acceptance Criteria**

- The person taking the sample must sign the request form and the sample tube as confirmation that the patient ID has been confirmed and that the sample tube is labelled at the patient's side. The requesting clinician's name must also be on the form.
- All samples must be in EDTA tubes.
- Sample tube details **must** be handwritten clearly. Addressograph labels are **not** acceptable on sample tubes, but can be used on the request forms.
  **The following** are required for fail-safe ID:
  **1. Full Forename** and **2. Surname**
  **3. Date of Birth 4. CHI Number**

If the patient does not have a CHI Number then the Hospital Number can be used.

**LAB USE ONLY**

Patient has NOT had an ALLO transplant in the last 12 months Y / N

Patient has NOT had a solid organ transplant in the last 3 months Y / N

Patient is NOT known to have antibodies Y / N

Results transferred to host via interface Y / N

Results have NOT been modified Y / N

IAT crossmatch must be performed if there is a "NO" response to any of the above questions