Dorevitch PATHOLOGY

Blood Product Request Form

18 Banksia Street Heidelberg Victoria 3084 **03 9244 0444**

RCPA NATA
NATA/RCPA Accredited Laboratory Number 2204

TO BE USED FOR CROSSMATCH/GROUP & HOLD SERUM (SAVE SERUM)/BLOOD PRODUCT ORDERING

PATIENT SURNAME	GIVEN NAMES		
D.O.B. / /	SEX M / F	UR No.	ACC To
ADDRESS			POSTCODE
PATIENTS PHONE	MEDICARE/REPAT No.	☐ PENSIONER ☐ REPAT	

REQUESTING PRACTITIONER Surname & Initials, Address, Tel No., & Provider No.

DR. .....

COPY TO _____

& WARD MADU

#WFP

REASON FOR TRANSFUSION & CLINICAL NOTES (MUST BE COMPLETED)

WESTERN HEALTH PATIENT: ENSURE UR NUMBER IS ENTERED WHEN REGISTERING PATIENT.
BLOOD TUBES MUST HAVE UR NUMBER RECORDED.
PLEASE SEND BLOOD BANK SAMPLE AND COPY OF REQUEST TO SITE OF TRANSFUSION.
WESTERN & WILLIAMSTOWN HOSPITALS - TO FOOTSCRAY LAB.
SUNSHINE & SUNBURY HOSPITALS - TO SUNSHINE LAB.

HOSPITAL LOCATION

.....

When required Date ... / ... / ... Time ..... am / pm

TESTS REQUESTED

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

URGENT RESULTS
TEL/FAX NO: ..... BY: ..... HRS

REQUIRED PRODUCT

1. GROUP AND HOLD SERUM ..... Yes / No
2. CROSSMATCH PACKED CELLS ..... units
   (Please indicate if required: Irradiated / Leucocyte depleted / CMV neg.)
3. AUTOLOGOUS CROSSMATCH ..... units
   (This form is **not** to be used for autologous collection)
4. PLATELETS ..... units
5. FFP ..... units
6. CRYOPRECIPITATE ..... units
7. OTHER (eg. Albumin) .....

Access these products through the normal service in your area; if required urgently contact the Red Cross Blood Transfusion Service.

INFORMATION REQUIRED FOR PRODUCT SUPPLY

Hb ..... gm/dL or Results Pending
Pregnancy in last 3 months? Yes / No
Transfusion in last 3 months? Yes / No
Anti D in last 3 months? Yes / No
Autologous blood donated for this procedure? Yes / No

Platelet count ..... x 10^9/L
Bleeding? Yes / No

INR ..... or PT ..... seconds
APTT ..... seconds
Bleeding? Yes / No

Plasma Fibrinogen ..... g/L
Bleeding? Yes / No

Doctors Signature ..... Name (print) ..... Date ... / ... / ...

PERSON DRAWING BLOOD I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of this patient by direct inquiry and/or by inspection of wrist band, and immediately upon the blood being drawn I labelled the specimen(s).

Signed ..... Surname (print) ..... Date ... / ... / ... Time ..... am/pm
Second signature if required

Signed ..... Surname (print) ..... Date ... / ... / ... Time ..... am/pm

OFFICE USE ONLY

Location	C V N H / P O L	Time	PR PU PA	QU	Fee Cat:
		:			WFO

COMPLETE FOR ALL PATIENTS

Patient status at the time of the service or specimen collection	Y	N
a) Private patient in a private hospital or approved day hospital facility	☐	☐
b) Private patient in a recognised hospital	☐	☐
c) Public patient in a recognised hospital	☐	☐
d) Out patient of a recognised hospital	☐	☐

A/C Class ☐ Hos ☐ BS ☐ In/Out patient ☐ WCA ☐ TAC ☐ Veterans ☐ Overseas ☐

For guidelines for appropriate product ordering & units required - see back of this form.