

Blood Transfusion OCS Downtime Request Form

Please complete ALL fields and print clearly in BLOCK CAPITALS

Current Hospital No: _____	
NHS No: _____	
Surname:	_____
Forename:	_____
DOB:	_____ Sex: _____
Ethnic Origin: _____	

This section MUST be completed by the person taking the sample:	
Collection Date (dd/mm/yy): _____	
Collection Time (hh:mm): _____	
Collected By (Sign and print): _____	
By signing above you confirm that you have Checked:	
✓	Patient's ID by confirming with the patient (if able)
✓	Details on request form and wristband match
✓	Handwritten the patients' full name, hospital no, DOB and

Hospital Site: _____ Location: _____

Consultant: _____

Requested By: _____ Bleep / Contact _____

Clinical Details: _____

Patient Transfusion History:

Has this patient been previously transfused?
If YES, give approx. date of last transfusion: _____

Is this patient known to have red cell antibodies?

Is the patient known to have any special blood/product requirements?
If YES, please specify: _____

Is this patient pregnant?
If YES, please specify EDD or state booking: _____

Investigations Requested (Please Tick):

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Group and Antibody Screen | <input type="checkbox"/> DAT | <input type="checkbox"/> Kleihauer |
| <input type="checkbox"/> New-born baby group | <input type="checkbox"/> Cord Group | |
| <input type="checkbox"/> External referral test (please specify) _____
(This may require an additional NHSBT request form) | <input type="checkbox"/> Other (please specify) _____ | |

Crossmatch / Blood Component Required (Please Tick):

- Red Cells
- FFP
- Platelets
- Other please specify _____

Please record the number of units, time & date required and clinical indication below		
Number of units	Date/Time	Clinical indication

Lab use only (Telepath labels, etc)