West of Scotland Blood Transfusion Service
25 Shelley Road
Glasgow G12 0XB
Tel: 0141- 433- 5808(RCI) / 5807 (XM) / 5800
Fax: 0141- 357 - 7788

AFFIX BAR CODE NO. (lab use only)

NHS National Services Scotland

RED CELL IMMUNOHAEMATOLOGY REQUEST FORM

Please ensure samples are clearly labelled with Surname, Forename, DOB, CHI/Hospital number, and Gender.
Sample tubes must be handwritten, dated, timed and signed by the person taking the sample. Use of addressograph on sample tubes is prohibited. There must be NO discrepancies between the details on the sample tube and request form.

Incomplete request forms or incorrectly labelled samples will not be processed in accordance with SNBTS zero tolerance policy.

NOTE: Each request accepted by West of Scotland BTC for testing shall be considered an agreement.

PATIENT IDENTIFICATION (Please Circle or Enter Details as Applicable)

SURNAME: _____ FORENAME: _____ PREVIOUS NAME(S): _____

D.O.B: _____ GENDER: M/F HOSPITAL No: _____ CHI: _____

HOME ADDRESS: _____

_____

DATE SAMPLE TAKEN: _____ TIME SAMPLE TAKEN: _____ SAMPLE TYPE: _____

REQUESTING HOSPITAL: _____ WARD: _____

REQUESTING CONSULTANT: _____ BLOOD GROUP (IF KNOWN): _____

CLINICAL INFORMATION (Please Circle or Enter Details as Applicable)

DIAGNOSIS: _____ KNOWN DANGER OF INFECTION: YES / NO

PREVIOUS TRANSFUSIONS: YES / NO / UNKNOWN NO UNITS TRANSFUSED: _____ DATE OF TRANSFUSION: _____

PREGNANT WITHIN PAST 3 MONTHS: YES / NO

DETAILS OF RED CELL ANTIBODIES (If Applicable): _____

ADDITIONAL INFORMATION: _____

OBSTETRIC INFORMATION (Please Circle or Enter Details as Applicable)

EDD: _____ PARITY: _____ CURRENT ANTIBODY TITRE: _____

CURRENT ANTI-D PROPHYLAXIS: YES / NO DATE: _____ DOSAGE: _____

ADDITIONAL INFORMATION: _____

REASON(S) FOR REFERRAL (Please Tick or Enter Detail as Applicable)

RBC ANTIBODY IDENTIFICATION		DIFFICULTY IN ABO GROUPING		ANTI-D QUANTIFICATION	
HAEMOLYTIC TRANSFUSION REACTION		DIFFICULTY IN Rh GROUPING		ANTI-c QUANTIFICATION	
ADDITIONAL SAMPLES REQUESTED BY SNBTS				OBSTETRIC TITRES	

OTHER _____

REPORT TO BE SENT TO:-

NAME:
_____

ADDRESS:

_____

_____

REPORT AUTHORISATION

BMS:_____

Medical Staff:

Copy Report ☐ Amended Report ☐

BMS: _____

Medical Staff:

BLOOD REQUIREMENTS (Please Tick or Enter Detail as Applicable)

MATCHED BLOOD REQ'D		SCREENED BLOOD REQ'D	

SPECIAL REQUIREMENTS: _____

NUMBER OF UNITS REQ'D: _____

IMMEDIATE ☐ TOP-UP ☐ ELECTIVE ☐

DATE & TIME REQUIRED: