**Refer to SNBTS Guidance for Completion of Red Cell Immunohaematology Request Form NATL 163.**

**AFFIX BAR CODE NO. (lab use only)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT IDENTIFICATION (Please Circle or Enter Details as Applicable)** | | | | |
| **SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FORENAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PREVIOUS NAME(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: M/F HOSPITAL/EMERGENCY 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**  **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)** | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **ABO INVESTIGATIONS/ANOMALIES** |  | **RhD TYPE CONFIRMATION** |  | **ANTIBODY IDENTIFICATION** |  | | **ANTIBODY QUANTIFICATION** |  | **HAEMOLYTIC TRANSFUSION REACTION** |  | **ANTENATAL/RENAL TITRATION** |  | | **DARA DTT/MONOCLONAL THERAPIES** |  | **CROSSMATCH** |  | **ADDITIONAL SAMPLES REQUESTED BY SNBTS** |  |     **OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COPY OF RESULTS ATTACHED: YES / NO**  **DETAILS OF RED CELL ANTIBODIES (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **REPORT TO BE SENT TO: -**  **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **BLOOD REQUIREMENTS**  **(Please Tick or Enter Details as Applicable)** | | | |
| **CROSSMATCHED BLOOD REQUIRED** |  | **PHENOTYPED BLOOD REQUIRED** |  |
| **SPECIAL REQUIREMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NUMBER OF UNITS REQUIRED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **IMMEDIATE TOP-UP ELECTIVE**  **DATE & TIME REQUIRED:** | | | |

**Please note: Submission of this request form to SNBTS is considered an agreement. The referring site acknowledges that SNBTS terms and conditions/Service Level Agreement apply.**