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

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

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| **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)** |
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| **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.**