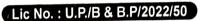


I.M.A. CHARITABLE BLOOD CENTRE

IMA Bhawan, 1, River Bank Colony, Lucknow, Uttar Pradesh - 226003 Ph.: 0522-3171416





RECOD / BEO	JD COMI O	NENT REQUISITIO	IV I OKI
PATIENT INFORMATION			
ame in Full:		Age :	Sex :
ddress:			
egistration No./ID No.:		Ward :	Bed No. :
iagnosis:			Blood Group
iagnosis :		,	Blood Group :
dication for Transfusion :			
O previous transfusion or any relev	ant history as a	adverse reaction, if any.	
ny relevant past obstetrics history :			
Ty relevant past obstetrics mistory.	······································		
DETAIL OF DEMAND OF BLOOD)		i i i i i i i i i i i i i i i i i i i
Type of Blood/Component	No. of Bags	Type of Blood	No. of Bags
Whole Blood		Random Donor Platelet	
PRBC		FFP	
Plasma Apheresis		Paediatric Unit/Parts	
Single Donor Platelet		Any Other	
equirement - Immediate/Urgent/Ro	utine :		
		•••••	
) HOSPITAL & DOCTOR INFORMAT		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
certify that have personally collected the	ne blood sample	after identification of pati	ent's ID No./CR No. an
nave explained the necessity of blood	transfusion and	risks associated with it t	o patient / relatives an
formed consent.			
ospital Name :		Govt/Pr	ivate :
ospital Registration No. :		·	
ospitai Registration No. :			
ospital Registration No. :ame of Consultant/MO In-charge :			No

- Send 3-5 ml of Blood in plain vial and 2ml in EDTA vial/vaccutainer.
- Do not send sample in syringe.

Date :

Time: AM/PM

Sample Vial to be labelled for Name, Ward & Bed No., CR, ID No at the patient's bedside only. Should use permanent marker.

Name & Sign of MO with Seal

- Requisition form and samples with discrepancy are unacceptable.
- This form will not be accepted, if not signed or any section is left blank.
- Do not insist for fresh blood. If any special needs should be mentioned clearly on requisition form.
- Send requisition form safely to avoid it's misuse.
- Haemolysed sample will not be accepted.
- For neonates less than 4 months, send mother's sample also in 3ml of plain vial for cross match.
- In retain case only get a receipt from the blood bank.
- In retain case of elective requirement blood bag will be stored for 3 days (72 hours) only.
- Every time fresh sample should be sent.

To be used by Blood Bank

identification matched with sample and vial (Yes/I	AM/PM on datepatient's
Signature of Receptionist :	Signature of Medical Technologist

Cross Match Record Patient's Blood Group

Cell Grouping		Serum Grouping			Blood Group			
Anti B	Anti A	Anti AB	Anti D	A cells	B cells	O cells	ABO	Rh (D)
	9				0 0 -			

Cross Match Report

SI. No.	Patient ID Donor Unit ID		Blood Group	Cross Match Done By	
1.	11 may 200 mg 4 mg 200 mg				
2.					
3.					
4.	,				
5.					

Remarks/Notes:

	Signature	of Me	edical	Techno	ologist
Date		Time		A	M/PM

SI. NO.