Annex 5: BLOOD REQUEST CROSSMATCH FORM

FULL NAME (PRINT CLEARLY)

Age	Sex **M** **F**	Hospital No.

Ward	Doctor In-Charge

Hospital

Date, Time Blood Collected

Diagnosis/Operative Procedure:	Race PNG CAUCASIAN MIXED OTHER

History: Previous Transfusion Yes: ☐ No: ☐
Previous Pregnancy Yes: ☐ No: ☐
If YES, Date ……………………………………………….
Hb if known ……………………………………………….
Blood Group (if known)…………………………….

LAB. USE ONLY Lab. No …………………………..

Date & Time Request Received ……………………..…………………………………

Group of Patient………………………………………………………………..…………………

CROSS MATCH RESULTS

Number on Blood Donor Bag	Group	S	Ram	AHG	Other

REMARKS

Date……………………………. Signed…………………………………

URGENCY:
☐ Desperate (Now)
☐ Emergency (1 Hr)
☐ Urgent (4-6 Hrs)
☐ For Surgery (24 Hrs)

BLOOD REQUIREMENTS: TIME BLOOD OR ITS COMPONENT IS REQUIRED
☐ Packed Cells………………………………… Units…………………………………………………(Date)
☐ Whole Blood …………………………….. Units ……………………………….(Time) a.m/p.m
☐ Others ……………………………………….. Units ……………………………… (Time) a.m/p.m

Name (DR) ……………………………………… Signed (Dr) ………………………..(Time) a.m/p.m

SEND 5 – 10 MLS CLOTTED BLOOD

NATIONAL BLOOD TRANSFUSION

Note: For neonates: 1-1.5 ml. Samples from neonates should be sent with the mothers for ABO, RhD status and DAT. Children: less than 5 mls