Blood Group & Compatibility Request Form

BT-0007 Version 8

Irish Blood Transfusion Service
Seirbhís Fuilaistriúcháin na hÉireann

MRTC Tel: 021-4807400 Fax: 021-4323315 Dublin Tel: 01-4322972 (8.30-7pm) 01-4322800 (Out of Hours) Fax: 01-4322709

IBTS Lab. No.

PATIENT DETAILS

Surname: __|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

First Name: __|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Maiden Name: __|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

D.O.B.: ___/____/____ Hospital Number: _____ Ethnicity:_____

Address: _____

_____ _____ Gender: Male ☐ Female ☐

eTraceline No.

Referring Hospital Sample No.

Hospital:_____Ward: _____ Consultant & Contact Information:_____

CLINICAL INFORMATION / TRANSFUSION HISTORY

Clinical Condition: _____ Known Haemoglobinopathies: _____

Hb: _____g/dL ON ___/___/____ Previous Transfusion: Yes☐ No ☐ Unknown ☐ Date of last transfusion:___/___/___

Has the patient ever had a transplant: Yes ☐ No ☐ Transfusion Reactions: Yes ☐ No ☐ Date: ___/___/____

Blood Group (if known): _____ Phenotype: _____ DAT: _____

Known Antibody/ies: _____ Current Transfusion Protocol: _____

Pregnant: Yes ☐ No☐ EDD:_____ Pregnant in past 3 months: Yes☐ No☐ Anti-D Ig: Yes ☐ No ☐ Date:_____

Please send copies of your serological investigations

DECLARATION

I have checked that this sample complies with the labelling requirements as per the Customer Manual for the Red Cell Immunohaematology & Diagnostic Laboratory. Print Name: _____

Medical Council No.: _____**Signature**: _____Date:_____ Time:_____

TEST AND COMPONENT/PRODUCT REQUESTS

Group and Antibody Screen/Hold: ☐ Other Tests:_____

Group and Crossmatch: ☐ No. of Units Required:_____ Date Required:_____Time:_____

Red Cells ☐ Platelets ☐ Frozen Plasma ☐

Please Indicate if patient has special requirements:

CMV Negative: Yes ☐ No ☐

Irradiated: Yes ☐ No ☐

Treat as an Emergency: Yes: ☐ **No:** ☐

Signed:_____(Treat as routine if unsigned)

IBTS MUST BE PHONED IF REQUEST IS URGENT

IBTS LABORATORY USE ONLY

SPECIMEN LABELLED

Surname: _____

First Name: _____

D.O.B.: ___/___/_____ Hospital No. _____

Lab Reference No.: _____

Date on Sample: ___/___/_____ Time: _____

Sample Type: **EDTA** ☐ **CLOTTED** ☐ Signed: Yes ☐

Data Check: _____ Date: ___/___/____

Suitable for testing: **Yes** ☐ **No** ☐

If NOT: Hospital Contacted: **Yes** ☐ Date: ___/___/____

File & History Check: _____ Date: ___/___/____

Labelling Verification Check: ___/___ Date: ___/___/____

CMV- **Yes** ☐ **No** ☐ Irradiated **Yes** ☐ **No** ☐

Antigen Neg Req'd **Yes** ☐ **No**☐ Sickle Cell **Yes** ☐ **No** ☐

Historical Ab Check **Yes**☐ Protocol Update: **Yes**☐ **N/A**☐

TELEPHONE AMENDMENTS

Amended Request:_____

_____

_____Requested By:_____

Call Received By: Date: ___/___/____ Time:_____

Amended Request:_____

_____

_____Requested By:_____

Call Received By: Date: ___/___/____ Time:_____

Patient Blood Group:	**Patient Antigen Type:**
Transfusion Protocol:	

IBTS Lab. No.

SPECIMEN AND LABELLING REQUIREMENTS

Specimen Requirements: Refer to IBTS Customer Manuals (IBTS/DIAG/CM/0001 (MRTC) & IBTS/RCI/CM/0001 (NBC))

Minimum Data for Labelling of Red Cell Serology/Blood Transfusion Requests and Samples

Sample Requirements: 6mL edta Sample (Children 2mL)

On request forms and Samples

1. Forename
2. Surname
3. Date of Birth
4. Hospital Number
5. Date, Time & Signature
6. Declaration section **MUST** be completed.

Additional Request Form Information

1. Patient Address
2. Location: Hospital and Ward
3. Patient's Gender
4. Test(s), number of units required
5. Name of Requesting Clinician
6. Relevant Clinical Information (drugs, ante-natal history, transfusion history, reason for transfusion, etc.)

1. Please print patient details clearly in block capitals.
2. Patient details must correspond with details on request form.
3. Illegible script and/or the use of abbreviated names will not be accepted.
4. Any corrections of clerical errors must be signed and dated. Please draw a line through the error and sign and date next to it.
5. Blood samples with addressograph labels will not be accepted.
6. Forms must have the declaration section completed.

The customer manual can be found at:

https://healthprofessionals.giveblood.ie/clinical-services/transfusion-transplantation/red-cell-immunohaematology-diagnostics/

IBTS LABORATORY USE ONLY

Forward Group	1st Group Read 1	Read 2	2nd Group Read 1	Read 2	3rd Group Read 1	Read 2
Anti-A						
Anti-B						
Anti-AB						
Anti-D						
Anti-D						
Control						
Reverse						
A1 Cells						
B Cells						

Antibody Screen	Cell 1	Cell 2	Cell 3
IAT			
Enz			
Sal RT			
Sal 4°C			

DAT	Poly	IgG	C3d	Ctl	IgM	IgA	C3c

Final Interpretation: ABO & Rh D type

Initials

_____ / _____

Phenotype: C___ c___ E___ e___ K___

Other Phenotypes: _____

Lab Comments: _____

_____

_____

_____

Antibodies Identified: _____

_____ **Antibodies Identified By:** ____

Antibody Titre(s): _____

Unit No.	Gp	IAT			Antigen Type	Label Initial	Unit No.	Gp	IAT			Antigen Type	Label Initial

Reviewed By: ____ **Date:** ___/___/___

Report To Med by:____**Date:**___/___/___

Reserved Products: Yes ☐ **No** ☐

Verified By: ____ **Date:** ___/___/___

Medical Comments:

Date and Time Received at IBTS