Mfg. Licence No. U.P./B&B.P/2023/01

HIND CHARITABLE BLOOD CENTRE

(Established & Run By Gramudyog Sewa Niketan)
Plot No. H-1, 1st Floor, Pratap Vihar, Vijay Nagar, Ghaziabad-201009 (U.P.)
Tel. : 0120-6351391 Mob. : +91-8750183787 E-mail : hindcharitablebloodcentre@gmail.com

Blood/Blood Component Requisition Form

Requsition Id

A) PATIENT INFORMATION

Name in Full : ..... Age : ..... Sex : .....

Gaurdian / Attendant Name ..... Mobile No.....

Address : .....

Hospital Name :.....

Registration No/ID No. : ..... CR No. ..... Ward : .....Bed No. : .....

Diagnosis : ..... Blood Group : .....

Indication for transfusion : ..... PL Tcount..... Hb %.....

H/O previous transfusion our any relevant history as adverse rection, if any :

Status of patient's viral Markers Test Hb%.....HCV.....HIV I&II.....HBSAG.....VDRL.....MP.....

An relevant past obstetrics history : .....

B) REQUIREMENT DETAILS OF BLOOD COMPONENT

Type of Blood/Components		Type of Components	
Whole Blood		Random Donor Platelet	
PRBC		FFP	
Plasma Apheresis		Paediatric Unit/Parts	
Single Donor Platelet		Any Other	

Requirement - Immediate / Urgent / Routine : .....

C) HOSPITAL & DOCTOR INFORMATION :

I certify that I have personally collected the blood sample after identification of patient's ID No./ CR No. and name. I have explained the necessity of blood transfusion and risks associated with it to patinet/relatives and taken informed consent.

Hospital Name : ..... Govt. / Private : .....

Hospital Registration No. :.....

Name of Consultant/MO In-charge :..... Mobile No. : .....

Doctor's Name (creating demand):..... Mobile No. : .....

RITESH SHARMA
8750183787

Date : .....

Time : ..... AM / PM Name & Sign of MO with Seal

To be used by Blood Bank

Sl. No. .....

Requisition received in Blod center at ..... AM/PM on date..... patient's

Identification matched with sample and vial (Yes/No) : .....

Signature of Receptionist / Issue counter Technicians : .....

Blood Group .....Signature of Medical Technologist .....

All Blood/Blood Components supplied are non reactive For HIV, HCV, HbsAg, VDRL & M.P. are Negative By Elisa Method.

Cross Match Record

Patient's Blood Group

For ward Grouping					Reverse Grouping			Blood Group	
Anti A	Anti B	Anti AB	Anti D	Anti A1	A cells	B cells	O cells	ABO	Rh(D)

Sl. No.	DONOR ID	Segment No.	Blood Group	Components	Auto control	Cross Match		Compatible	
						Major	Minor	Yes	No
1.									
2.									
3.									
4.									
5.									
6.									

- मरीज का ब्लड प्लेन और EDTA Vial में अलग-2 भेजें।-
- ब्लड सैम्पल पर मरीज का नाम लिखा होना चाहिए।
- हर Blood Demand के साथ मरीज का सैम्पल लाना जरूरी है।
- एक बार ब्लड Issue होने के बाद वापिस नहीं होगा।

Cross Match done by _____

Date & Time _____

Counter checked by :

Name .....

Signature .....

Date.....**Time** .....**AM / PM.**

- **Send 3-5 ml of blood in plain vial and 2ml in EDTA vial/vaccutainer.**
- **Do not sent sample in syringe.**
- **Sample Vial to be labelled for Name, Ward & Bed No., CR, ID No. at the patient's bedside only. Should use permanent marker.**
- **Requisition for and sample with discrpancy 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 from.**
- **Send requistion form safety 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 of elective requirements blood bag will be stored for 3 days (72 hours) only.**
- **Every time fresh sample should be sent.**