North Bay Regional Health Centre

Department of Laboratory Services
Transfusion Medicine Requisition

Submitting Doctor: _____ Signature: _____

Collection Date: _____ Time: _____ Collected By: _____

☐ O.R. Procedure: _____ Date: _____ Time: _____

Clinical History: (required)

Gender: ☐ Male ☐ Female ☐ Unknown
Past Transfusion: ☐ YES ☐ NO Date of most recent blood transfusion: _____
Pregnancy: ☐ YES ☐ NO Gravida #:_____ Para #:_____ Still Birth #:_____

Medications: Is the patient taking any anti-Hypertensive Drugs? ☐ YES ☐ NO
Special CMV negative and/or irradiated blood product required? ☐ YES ☐ NO
Specify: ☐ CMV Neg ☐ Irradiated

Test Requested: ☐ Routine ☐ Urgent ☐ STAT

☐ Group & Rh
☐ Antibody Screen
☐ Group & Screen: ☐ Screen & Hold Plasma
☐ Prenatal
☐ Rh Immune Globulin
☐ IVIG
☐ Cross Match #:_____Units of Blood

☐ Antibody Identification
☐ Direct Antiglobulin Test (DAT)
☐ Antibody Titre
☐ Rh Probable Genotype
☐ Cold Agglutinins Screen
☐ Transfusion Reaction Investigation
☐ Other Specify: _____

Blood Product (s) (Requested):

☐ Packed Cells #: _____
☐ Frozen Plasma #: _____
☐ Platelets #: _____
☐ Cryoprecipitate #: _____
☐ Immune Globulin # (specify): _____
☐ Other (specify): _____

Patient's Results: (for laboratory use only)

Name: _____

Hospital Number: _____

	Anti			Cells		Anti	Ctl	Interpretation	
	-A	-B	-AB	A	B	D	D	Group	Rh
Blood Group:	_____	_____	_____	_____	_____	_____	_____	_____	_____

Rh Most Probable Genotype: _____/ _____, _____/ _____

Antibody Screen: I _____ II _____ III _____ Interpretation: _____

Antibody (ies) I.D.: _____ Antibody Titre: _____

DAT (AHG): _____ DAT (-IgG): _____ DAT (-C3d): _____ Interpretation: _____

Blood Products:

	Unit # / Lot #	Group/Rh	Imm Sp	Gel-IgG	Compatible (Y / N)	Issued (Y / N)
1						
2						
3						
4						
5						
6						

Testing Completed by (tech): _____ Date: _____ Time: _____

1. Issued By: _____ Issued To: _____ Date: _____ Time: _____
2. Issued By: _____ Issued To: _____ Date: _____ Time: _____
3. Issued By: _____ Issued To: _____ Date: _____ Time: _____
4. Issued By: _____ Issued To: _____ Date: _____ Time: _____
5. Issued By: _____ Issued To: _____ Date: _____ Time: _____
6. Issued By: _____ Issued To: _____ Date: _____ Time: _____

Results Phones/Faxed To: _____ by (Tech): _____

Date: _____ Time: _____ Tech: _____

Physician Approval In Case of Emergency or Difficulties.

Transfusion Approved By: _____ MD (print) Date: _____ Time: _____