[](https://www.giveblood.ie/)

**Blood Group & Compatibility Request Form BT-0007 Version 7**

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: \_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

**eTraceline No.**

D.O.B.: \_\_\_/\_\_\_\_/\_\_\_\_ Hospital Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Hospital Sample No.**

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: MaleFemale

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 User 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

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

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Treat as routine if unsigned)

**IBTS MUST BE PHONED IF REQUEST IS URGENT**

Please Indicate if patient has special requirements:

**CMV Negative:** Yes No

**Irradiated:** Yes No

**IBTS LABORATORY USE ONLY**

**TELEPHONE AMENDMENTS**

**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 & Protocol Update: **Yes**

Amended Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Requested By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Call Received By: Date: \_\_\_/\_\_\_/\_\_\_\_ Time:\_\_\_\_\_\_\_\_

Amended Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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 User Manuals (IBTS/DIAG/UG/0002 (MRTC) and IBTS/RCI/UG/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. 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.

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.)

**The laboratory user guide can be found at:**

*https://www.giveblood.ie/Clinical-Services/Red-Cell-Immunohaematology-Diagnostics*

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| **IBTS LABORATORY USE ONLY** | | | | | | | | | | | | | | | | | | | | | |
| **Forward Group** | **1st Group**  **Read 1 Read 2** | | | **2nd Group**  **Read 1 Read 2** | | | **3rd Group**  **Read 1 Read 2** | | | **Antibody Screen** | | **Cell 1** | | | **Cell 2** | | | **Cell 3** | | |
| **Anti-A** |  |  | |  |  | |  | |  | **IAT** |  | | | |  | | |  | | |
| **Anti-B** |  |  | |  |  | |  | |  | **Enz** |  | | | |  | | |  | | |
| **Anti-AB** |  |  | |  |  | |  | |  | **Sal RT** |  | | | |  | | |  | | |
| **Anti-D** |  |  | |  |  | |  | |  | **Sal 4⁰C** |  | | | |  | | |  | | |
| **Anti-D** |  |  | |  |  | |  | |  |  | | | | | | | | | | |
| **Control** |  |  | |  |  | |  | |  | **DAT** | **Poly** | | **IgG** | **C3d** | | **Ctl** | **IgM** | | **IgA** | **C3c** |
|  |  |  | |  |  | |  | |  |  |  | |  |  | |  |  | |  |  |
| **Reverse** |  | | |  | | |  | | | **Phenotype: C**\_\_\_ **c**\_\_\_ **E**\_\_\_ **e**\_\_\_ **K**\_\_\_  **Other Phenotypes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Lab Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Antibodies Identified:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Antibodies Identified By:**\_\_\_\_  **Antibody Titre(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **A1 Cells** |  |  | |  |  | |  |  | |
| **B Cells** |  |  | |  |  | |  |  | |
|  |  |  | |  |  | |  |  | |
|  |  |  | |  |  | |  |  | |
| **Final Interpretation:**  **ABO & Rh D type** | | |  | | | **Initials**  **\_\_\_\_\_\_ / \_\_\_\_\_\_** | | | |
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| **Unit No.** | **Gp** | **IAT** |  |  | **Antigen**  **Type** | **Label**  **Initial** | **Unit No.** | **Gp** | **IAT** |  |  | **Antigen**  **Type** | **Label**  **Initial** |
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**Medical Comments:**

**Reviewed By: \_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_**

**Report To Med by:\_\_\_\_Date:\_\_\_/\_\_\_/\_\_\_**

**Reserved Products: Yes No**

**Verified By: \_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_**

**Date and Time Received at IBTS**

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