



PATH LINKS

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# Pathology Request

REQUEST FOR GROUPING, BLOOD AND/OR BLOOD PRODUCTS

JB-22533



PRINT CLEARLY - DO NOT USE ADDRESSOGRAPH LABELS ON BLOOD TRANSFUSION SAMPLES

Path Links **NHS**

HOSPITAL NUMBER	NHS NUMBER	HOSPITAL	WARD/LOCATION	CONSULTANT/GP
SURNAME	DATE OF BIRTH	REQUESTING CLINICIAN	SIGNATURE	BLEEP/TEL
FORENAMES	MALE <input type="checkbox"/>	NHS PP CAT II	DATE COLLECTED	TIME
	FEMALE <input type="checkbox"/>			COLLECTED BY

CLINICAL DETAILS (DIAGNOSIS OR REASON FOR TRANSFUSION)

PREVIOUS TRANSFUSIONS (GIVE DATES)

PREVIOUS PREGNANCIES (YES/NO)

IRREGULAR ANTIBODIES

IF HIGH RISK AFFIX STICKER HERE

### TRANSFUSION REQUIREMENTS

Tick Box  GROUP & SAVE

Tick Box  CROSSMATCH

Tick Box  FFP / CRYO No. .... Important: Contact Lab.

No. OF UNITS .....

Tick Box  PLATELETS No. .... Important: Contact Lab.

Date Required .....

OTHER TEST (SPECIFY) .....

Time Required .....

PREVIOUS BLOOD GROUP.

SPECIAL REQUIREMENTS FOR TRANSFUSION (Specify)

### LABORATORY USE ONLY

	Donation Number	Group	Expiry	Res.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

RAPID GROUP	Sig.	CONFIRMED GROUP	Sig.
<b>Rh</b>		<b>Rh</b>	

ANTIBODY SCREEN				Sig.	LAB NO.
I	II	III			