LILONGWE INSTITUTE OF ORTHOPAEDICS & NEUROSURGERY
BLOOD & BLOOD PRODUCTS REQUISITION FORM

Patient Details			**Hospital Details**	**Diagnosis/Clinical Detail**
FIRST NAME & SURNAME :			Ward/Cost centre:	
Sex	M	F		
Date of Birth			Hospital Number (Specific to Patient)	
Age if DOB Unknown				

BLOOD REQUIREMENT					
Test Requested:	Blood Group	Grouping & Cross Matching	Direct Coombs	Indirect Coombs	
Amount of Blood/Products Required	Cryoprecipitate	FFP	Platelets	Whole Blood/Packed Red Cells	
Urgency	Standard (24 hrs)	Emergency	Blood Group	Haemoglobin:	_____g/dl
Day & Date Blood Required		Time Required		Hct/Pcv :	_____%
Any previous transfusion: YES / NO / NOT KNOWN. If yes : When?: where?:			Has the Patient ever been pregnant? Yes / No / Not Known / NA Is the Patient pregnant now? Yes / No		
Clinician's Name		Clinician's Signature		Date and Time Sample collected	

FOR LABORATORY USE ONLY

(Details on specimen agree with those on request form.) **Yes:** ☐ **No:** ☐

Pack No	**ABO**	**RhD**	**Product Type**	**Cross Match**		**Date & Time X-Matched**	**Expiry Date**	**X-matched by**
				Saline	**IAT**			

Reviewed by: **Lab Ref No**