MUZAFFARNAGAR MEDICAL COLLEGE
& Associated Mahesh Hospital, Muzaffarnagar

Opp. Begrajpur Industrial Area, Meerut Road, Muzaffarnagar (U.P.) Ph. 01396-252702, 252704

BLOOD REQUEST FORM

Requirement	Whole Blood	Red Cells	Platelets	FFP
Number of Units				

Date of Requirement ..... Routine / Urgent / Immediate .....

PATIENT DETAILS :

Name ..... Father/Husband Name .....

Age & Sex ..... Ward ..... Bed .....

Registration No. ..... Doctor Incharge .....

Diagnosis .....

Blood Group if known ..... Previous transfusions Yes / No Any Reaction Yes / No

If yes Detail of Reaction .....

Reason for transfusion .....

FOR FEMALE PATIENTS ONLY

History of pregnancy Yes / No History of HDNB, Stillbirth. Abortion Yes / No

Name & Signature Doctor Incharge ..... Date & Time .....

INSTRUCTIONS

1. 5 ml. of patients blood in sterile labeled tube must be sent with the request form.
2. In a New Born Baby up to 6 months old, send the mothers blood sample also.
3. **All requests must accompany replacement donor.**
4. All the routine Blood demands must be sent to Blood Bank before 1 PM on working days.

FOR BLOOD BANK USE ONLY

Request received on date ..... Time .....

Patients Blood Group ..... Signature of the technician .....

Received Unit of Blood against Replacement Donor No. .....

COMPATIBILITY TESTING

Cross matched Units	Expiry	ABO Cross Match	AHG Cross Match	Date of cross Match	Tested by

BLOOD ISSUED

Unit issued	Date & Time issued	Issued by	Received by