Received on …… at …… Signature……
(Name in Block Letters)

INDIAN RED CROSS SOCIETY, BLOOD BANK

1, Red Cross Road, New Delhi-110 001
Phone: 23711551, 23716441-43 Ext. 334

Issue No. ……

BLOOD REQUISITION FORM

BEFORE FILLING UP THE FORM PLEASE FOLLOW THE INSTRUCTIONS GIVEN BELOW:

1. 5 ml patient's blood in plain sterile test tube (12x100 mm), with stopper and properly labeled.
2. The Requisition Form must be completed in all respects.
3. All requests must accompany replacement of donors.
4. The indication for transfusion should be clearly mentioned.
5. To carry the blood/blood products the relative/patient's attendant should be instructed to bring thermocole container. It is advised that the hospital authorities themselves should arrange to collect blood rather than through the relatives attendants.
6. Requisitions for emergency requirements are accepted round the clock.
7. Requisition for routine demands accepted between 9:30 am to 1:30 pm and 2pm to 3 pm.
8. Rs. 500/- (Rs. Five hundred only) per bag will be charged for consumables, testing charge & service charge and there will be no charge for the blood or its components.
9. Blood will be issued after testing, which will take approximately 3 hrs.
10. Once the blood issued it will not be taken back.
11. Follow up condition of the patient after the transfusion should be informed to IRCS.

Patient's Name : ……
(*In capital letters*)

Age:…… Sex: M/F Weight:…… kg

Father's /Husband Name: ……

FOR THE USE OF BLOOD BANK

Blood Group & Rh: ……
Tested by: ……
(Name in Block Letters)
X-Matched bag No./s ……
X-Matched by : ……
(Name in Block Letters)

Patients Regd. / Admn. No. …… Ward …… Bed No. ……

Hospital Name ……Doctor Incharge ……

Clinical diagnosis with short history: ……

……

Routine or Emergency (with justification)/Indication……

History of Previous Transfusion Yes | No Date : …… Name of institution ……

Blood/Plasma/Platelets etc…… ABO group …… Rh……

Any Transfusion reaction ……

For Female Patient: Married/Unmarried Pregnant: Yes/No History of Hemolytic disease of new born baby (HDNB)/Still birth/ Miscarriage Para ……

Required Blood Unit **Whole Blood** **Packed Cells** **FFP** **Plasma** **Platelet conc**

No. of units Reqd. …… on …… at ……

Dated : …… Time: ……

Name of the Referring Doctor ……

Contact details (Hospital Phone No.) …… **(E-mail ID)** ……

Doctor's (Mobile No.) ……

Signature of the Medical Officer
(Name in Block Letters)
Designation & Stamp of Nursing Home/Hospital

FOR USE OF IRCS BLOOD BANK

NAME OF THE PATIENT ……..…AGE: ……SEX: ……

PATIENT'S GROUP

CELL GROUPING				SERUM GROUPING				GROUP	
Anti-A	Anti-B	Anti-AB	Anti-D	A1 Cells	A2 Cells	B Cells	O Cells	ABO	Rh.(d)

Antibody Screening in pts serum : In Saline …….. In Alb/Enz/AHGS …….

Direct Coomb's Test on Patient's cells (if needed) ……

CROSS MATCH

Blood Group	Donor's Bag No/s	Major For		Minor For		Compatible Yes/No
		1gM	1gG	1gM	1gG	

Remarks (if any) ……..

……
Crossmatched by
(Full Signature)
……
(Name in Block Letters)

Received …… Units of W.B./Red Cells/Plasma/Plated conc.
on …… at …….. against No. ……..

Issued by……..
(Full Signature)
……..
(Name in Block Letters)

Received by ……
(Full Signature)
……
(Name in Block Letters)
Relationship……..