

# Group and save or crossmatch requests

- Ensure you have the **correct request form**
- Confirm **verbal ID with patient**
- Check their details against **practice record**
- **CHECK FOR SPELLING & TRANSCRIPTION ERRORS**

**HANDWRITE AT PATIENT'S SIDE:**

- ✓ Full name
- ✓ MRN/NHS no.
- ✓ Date of birth
- ✓ Your **SIGNATURE**
- ✓ Date & time



HAVE YOU LABELLED THE SPECIMEN CORRECTLY?  
 PRESS FIRMLY ON EACH END TO ENSURE A LEAKPROOF SPECIMEN CARRIER

BLOOD BANK

BLOOD TRANSFUSION LABORATORY

NHS

PATIENT NO: 22212009 B

JPB-32109

JOHNS & BROOKS D1706 045058

BLOOD TRANSFUSION LABORATORY, ROYAL UNITED HOSPITAL, COMBE PARK, BATH

ALL S...

SHAD...

DO NOT ATTACH PRE-PRINTED OR ICE LABELS TO SPECIMENS, ATTACH LABELS TO REQUEST FORM BELOW

RUH MRN (Hospital number) NHS NUMBER Required for sampling outside RUH

SURNAME FORENAME

DATE OF BIRTH DD MM YY SEX M F 1st LINE OF PATIENT ADDRESS POSTCODE

WARD/GP PRACTICE/LOCATION ADDITIONAL COPY TO:

USE PLEASE...

GROUP & SCREEN ONLY CROSSMATCH (Packed Red Cells) DIRECT COOMBS TEST

UNITS DATE REQUIRED TIME TRANSFUSION LOCATION

REASON FOR REQUEST

FOR ALL OTHER BLOOD PRODUCTS, PLEASE CONTACT THE LABORATORY LIST BELOW ANY SPECIAL REQUIREMENTS e.g. Irradiated products

SAMPLE TAKEN BY (MUST BE COMPLETED IN ALL CASES)

I certify that I have confirmed the identity of the patient at the time of sampling

Sign Print

Date of Collection / / Time :

BELOW, THIS SECTION...

Technique Cr Initial

Polyspecific DO Tube

Result Card Lot Initial

Date / / Tick when panel added

This area may be completed already. If not, please complete as instructed by the requester

Complete **ALL DETAILS** in shaded mandatory area.

OR: If pre-printed label already in place, **check these details verbally with your patient and against their record**

**Sign & print YOUR name.**

Complete date & time of collection

Samples will be **REJECTED** if not 100% correct. This can lead to unacceptable delays in patient treatment.

**TAKE CARE!**