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| **Special Requirements of Blood Transfusion Laboratory Request Form** |

This form should be completed for **all** patients who have special requirements for blood components. A copy should be sent to Blood Bank and a copy filed at the front of the patients clinical notes. It is the responsibility of clinicians to update Blood Bank on any changes to special requirements. A minimum annual review is required. Additional forms are available from the transfusion page on Staffnet.

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| **Patient Details** *(Addressograph label if available*) | **Referring Consultant** | | |
| Surname: | Consultant: | | |
| First Name(s): | Hospital: | | |
| DOB: | Location: | | |
| CHI Number/ TJ Number: | Contact Number | | |
| Sex: |  | | |
| **Blood Product Requirements** (Please tick (🗸) in **white** column as appropriate, see below table for Haemoglobinopathy Patients and plasma reduced components) | | | |
|  | | CMVSeronegative | Irradiated |
| Neonates up to 28 days post EDD | |  |  |
| Intrauterine Transfusion (for 6 months after 40 weeks gestation) | |  |  |
| Neonatal Exchange Transfusion (ET) | |  |  |
| All donations from first or second degree relative | |  |  |
| Severe T lymphocyte immunodeficiency syndromes including  Di George and Severe Combined Immunodeficiency | |  |  |
| Recipients of allogeneic haemopoietic stem cell transplantation (HSCT) | |  |  |
| Recipients of autologous haemopoietic stem cell transplantation (HSCT) | |  |  |
| Stem cell harvesting | |  |  |
| All recipients of alemtuzumab (Campath, anti CD-52) | |  |  |
| All patients with Hodgkins lymphoma | |  |  |
| All patients treated with purine analogues, e.g. fludarabine, cladrabine, deoxycoformicin, clofarabine | |  |  |
| Patients with aplastic anaemia treated with immunosuppressive therapy (until lymphocyte count >1.0 x109/L) | |  |  |
| Patients with aplastic anaemia (potential stem cell transplantation) | |  |  |
| Pregnant woman | |  |  |
| **Haemoglobinopathy Patient**  (Full Rhesus and Kell matched, HbS negative products required) | | Document indication here: | |
| **Plasma Reduced Components (Washed cells)**  **Please see policy for indications** | | Document indication here: | |
| Alert recorded on: Portal **□** Trakcare **□** (Responsibility of the Consultant named below) | | | |
| Consultant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Review of Blood Product Requirements** *(Tick as appropriate)* | | | |
| CMV Seronegative **□** Irradiated **□** Plasma Reduced (Washed) **□** Other **□** | | | |
| Reason for change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective from (date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | | | |
| Consultant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **For Laboratory Use Only** *(Tick as appropriate)* | | | |
| Information transcribed into LIMS System **□**  Scanned copy of form sent via generic email address to the SNBTS and GJNH Blood Banks **□**  Copy of completed form sent to referring Consultant **□**  BMS Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |