Blood Product Request Form

Dorevitch PATHOLOGY 50 YEARS

RCPA NATA
Accreditation Number 2204
Accredited for compliance with NPAAC standards and ISO 15189

Healius Pathology Pty Ltd, ABN 84 007 190 043 APA 000042, trading as Dorevitch Pathology.

TO BE USED FOR CROSSMATCH/GROUP & HOLD BLOOD PRODUCT ORDERING

03 9244 0444

PATIENT SURNAME | **GIVEN NAMES**

D.O.B. / / | SEX M / F | UR No. | ACC To

ADDRESS | POSTCODE

PATIENTS PHONE | MEDICARE/REPAT No. | ☐ PENSIONER ☐ REPAT

REQUESTING PRACTITIONER Surname & Initials, Address, Tel No., & Provider No.

DR .....

PROV .....

EMPLOYEE NO: MANDATORY ☐ ☐ ☐ ☐ ☐

COPY TO

BALLARAT HEALTH SERVICES
BASE HOSPITAL
HOSPITAL & WARD WARD.....

REASON FOR TRANSFUSION & CLINICAL NOTES (MUST BE COMPLETED)

? TRANSFUSION REACTION

Do not send reports to My Health Record ☐

HOSPITAL LOCATION

.....

When required: Date: ..... /..... /..... Time: ..... am / pm

TESTS REQUESTED

G&H, COOMBS	(PINK TOP TUBE)
RETICULOCYTES	(PURPLE TOP TUBE)
BILIRUBIN	(GOLD GEL TOP TUBE)
MSU	(YELLOW TOP CONTAINER)
BLOOD CULTURES - IF FEBRILE	

.....

.....

.....

URGENT RESULTS

TEL/FAX NO:..... BY:..... HRS

REQUIRED PRODUCT

1. GROUP AND HOLD ..... Yes / No
2. CROSSMATCH RED CELLS ..... units

   (Please indicate if required: Irradiated / Fresh (< _____ days) / CMV neg.)
3. PLATELETS ..... units
4. FFP ..... units
5. CRYOPRECIPITATE ..... units
6. OTHER (eg. Albumin).....

INFORMATION REQUIRED FOR PRODUCT SUPPLY

Hb ..... gm/dL or Results Pending

Pregnancy in last 3 months? Yes / No

Transfusion in last 3 months? Yes / No

Anti D in last 3 months? Yes / No

If the answer to any of the questions above is "YES" – a Crossmatch, Group and Hold cannot be extended past 72 hours (3 days) from collection.

Known red blood cell antibodies Yes / No

If yes, please specify .....

Platelet count ..... x 10^9/L

INR .....or PT ..... seconds

APTT..... seconds

Fibrinogen ..... g/L

Bleeding? Yes / No

Doctor to sign ▶ Doctors Signature ..... Name (print) ..... Date ..... / ..... /.....

PERSON DRAWING BLOOD I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of this patient by direct inquiry and/or by inspection of wrist band, and immediately upon the blood being drawn I labelled the specimen(s).

Signed..... Surname (print)..... Date ..... /..... /..... Time..... am/pm

Patient to sign ▶ X..... Practitioner's Use only.....
(Reason patient cannot sign)

Patient's Signature Date: ..... / ..... / .....

Medicare Assignment (section 20A Health Insurance Act 1973) I offer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology services and any eligible pathologist determinable service(s) established as necessary by the practitioner. Patient Account Statement: Your doctor has requested tests on a clinical basis. Some of these may not be eligible for a Medicare rebate, and you may receive an account. For full details refer to Dorevitch Pathology Billing Policy as found on the website. dorevitch.com.au

OFFICE USE ONLY

Location	C V N H P O L	Time :	PR PU PA	QU	Fee Cat:

COMPLETE FOR ALL PATIENTS

Patient status at the time of the service or specimen collection	Y	N
a) Private patient in a private hospital or approved day hospital facility	☐	☐
b) Private patient in a recognised hospital	☐	☐
c) Public patient in a recognised hospital	☐	☐
d) Out patient of a recognised hospital	☐	☐

A/C Class ☐ Hos ☐ BS ☐ In/Out patient ☐ WCA ☐ TAC ☐ Veterans ☐ Overseas ☐

For guidelines for appropriate product ordering & units required refer to https://transfusion.com.au/blood_products/ and https://www.blood.gov.au/pbm-guidelines