Received on.....at.....Sig.....

REGIONAL BLOOD TRANSFUSION CENTRE : CENTRAL ZONE
LOK NAYAK HOSPITAL : NEW DELHI - 2

Phones -3232400, 3233400 Ext. 4301, 4219

Issue No.....

BLOOD REQUISITION FORM

Nursing Home/
Hosp. Name.....
.....

Patient's Name.....
(in capital letters).

Father's/Husband's Name.....
.....

FOR THE USE OF BLOOD BANK

Blood Froup & Rh.....

Tested by.....

X-matched bag Nos.:
.....

Tested by.....

X.Matched by.....

Whole Blood/Packed Cells/Plasma/Platelet conc.

Patients Regd./Admn.No.....Age.....Sex.....

Doctor Incharge.....Ward.....Bed/Room No.....

Clinical diagnosis with short history.....
.....

Routine or Emergency(with justification).....

History of Previous Transfusion.....

Yes/No if yes.....ABO group.....Rh.....

Reactions if any.....

If patient is Woman has she ever been pregnent.....

Yes/No.....Para History of

HD NB/Still birth miscarriage.

No. of Unit Reqd.....on.....At.....

dated.....Time.....

Signature of Medical Officer
with Designation & Stamp