

**Patient Details** U.R. No. ....

Surname: ..... Given names: .....

Address: .....

Postcode: ..... Tel No. ....

DOB: ..... Sex: .....

MEDICARE or DVA (Repat) Number

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Hosp	Ward	Lab number (lab use only)
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DATE/TIME REQUIRED:	IF URGENT or Bleeding Phone Blood Bank <input type="checkbox"/>	Within 2 hours <input type="checkbox"/>	NOT Urgent <input type="checkbox"/> (Date) .....
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**Tests Requested:**  
Group & Screen is valid for 3 days

See reverse.

**Clinical Notes / Indication for Transfusion**  
Specify indications below

**Special Product Requirements** (See Indications Overleaf)  
Specify indications below

**Irradiated**  .....

**CMV Negative**  .....

**Apheresis platelets**  .....

**Transfusion History**  
(must be completed for extended expiry)

	Yes	No	Unknown
Transfusion in last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous reaction to blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy/miscarriage in past 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Requesting Doctor (Must Sign & Date)**

Doctor code: ..... Provider No: ..... Pager No: .....

Surname:(print)..... Initials: .....

**Doctor's Signature:** ..... Date: / /

**Current Pregnancy** ..... weeks

**Anti-Rhd Ig last given** ..... weeks ago

Patient status at the time of service or when the specimen was collected

Private patient in a private hospital or approved day care facility     Private patient in a recognized hospital

Public patient in a recognised hospital     Outpatient of a recognized hospital

**Person Drawing Blood Specimen (must sign and date)**

I \_\_\_\_\_ (PRINT NAME) 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 inspection of wrist band, and immediately upon the blood being drawn I labelled the specimen(s) and signed the tube(s), including date and time.

**SIGNED** \_\_\_\_\_ **Date:** / / **Time:** \_\_\_\_\_

**MEDICARE ASSIGNMENT FORM Section 20A of the Health Insurance Act 1973**  
(not required for inpatients)

**Practitioner's Use Only**

Reason patient cannot sign \_\_\_\_\_

Is the patient the assignor:  Yes  No  
I assign my rights to benefits to the approved practitioner who will render the requested pathology service(s) and any pathology-determinable services.