



LAB No.:	Ward:	PT ID													
	Unit:	SURNAME ..... D.O.B. .... OTHER NAMES ..... SEX ..... ADDRESS ..... MARITAL STATUS ..... REL. ....													
Patient status at the time of collection (Please circle)		LABEL													
a) Private patient in a private hospital or approved day hospital facility?		Y N													
b) Private patient in a recognised hospital?		Y N													
c) A public patient in a recognised hospital?		Y N													
d) Out patient in a recognised hospital?		Y N													

Medicare No. or DVA No.		Samples must be handwritten
Practitioner's Use Only (Reason patient cannot sign)	Patient's Signature and Date ..... Medicare Assignment (Section 20A of the Health Insurance Act 1973). By this declaration I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s).	

Collector & Witness	<b>Person collecting the blood to complete:</b> I certify that I collected the accompanying sample from the above patient, whose identity was confirmed by inquiry and/or examination of their name band, and that I labelled the sample immediately following collection (label must include: Surname, Given name, PT ID, DOB, Date/Time and initials of collector.)  Signed: ..... Designation: .....  Surname: ..... Date: ..... Time: .....	<b>Person witnessing the collection of sample</b> I have witnessed the sample being taken and can verify that the request and blood sample matches the patient identity.  Signed: .....  Surname: .....
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Medical officer to Complete Fully Please	<b>Clinical Indications for Transfusion</b> – Refer to hospital guidelines – see reverse	<b>Test Requested:</b> eg BGH, BGA
		<b>Product Requested</b>
		Packed Cells
		Platelets
		FFP
		Cryo.
		Alburex 4
		Alburex 20
		Anti-D
		Other - please specify
	<b>Irradiation Requirement</b>	
	Yes No	
	<b>Requesting Doctor to Complete; (Provider No. surname and initials, address)</b> [Remember to sign the sample tube and collector's area of this form if you are also the collector]. Name: (Print - Surname and initials) ..... Doctor's Stamp / Provider No. Signature: ..... Mobile/Pager: ..... Address: ..... Date: ..... Copies to: .....	

Lab Use Only	Samples are held for a period of 30 days, unless the patient has been transfused or pregnant in the last 3 months – in this case the sample is held 3 days from the date of collection. Blood will be available for 2 days from the anticipated date of transfusion.  Batch Number ..... Taken By ..... Time/Date ..... Ward .....
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## Indications for Red Cell Transfusion

**Transfusion of red cells is generally not appropriate if the patient Hb is >80g/L unless they have one or more of the following** - Ongoing Bleeding, Symptomatic Anaemia, Impaired Cardiac or Pulmonary Reserve, Bone Marrow Dysfunction.

Platelet Count	Indications for Platelet Transfusion
< 10 X 10 <sup>9</sup>	As prophylaxis in bone marrow failure.
10- 20 x 10 <sup>9</sup>	Likely to be appropriate in the presence of fever.
< 50 x 10 <sup>9</sup>	Appropriate in the context of massive haemorrhage/transfusion. Maintain platelet count at > 50 x 10 <sup>9</sup> in patients undergoing surgery or invasive procedures.
Any Bleeding Patient	Appropriate when thrombocytopenia is considered a major contributory factor.
Any platelet count	For inherited or acquired qualitative platelet function disorders, depending on clinical features & setting.

## Prothrombinex, FFP and Cryoprecipitate

These products should only be ordered in consultation with a haematologist.

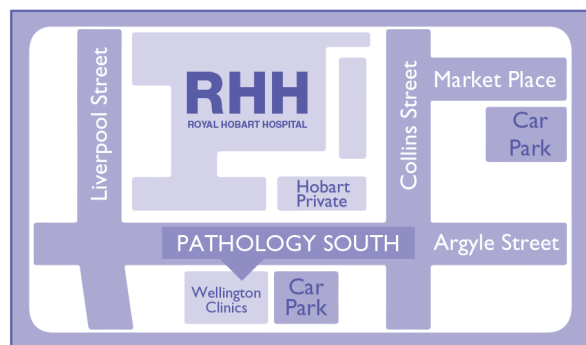
## After Hours Transfusion (1800-0800)

**After hours transfusions if required, should be done only after the approval of the relevant consultant. Refer to guidelines.**

	Irradiation Guidelines:
<b>Irradiated products are indicated where the patient is highly immunosuppressed and specifically in the following conditions:-</b>	<ol style="list-style-type: none"> <li>1. Haematopoietic Stem Cell transplant recipients.</li> <li>2. Aplastic anaemia</li> <li>3. Car-T therapy</li> <li>4. Hodgkin's Disease</li> <li>5. Acute Leukaemia</li> <li>6. Severe Congenital T lymphocyte immunodeficiency</li> <li>7. Patients receiving nucleoside analogues -or alemtuzumab</li> </ol>

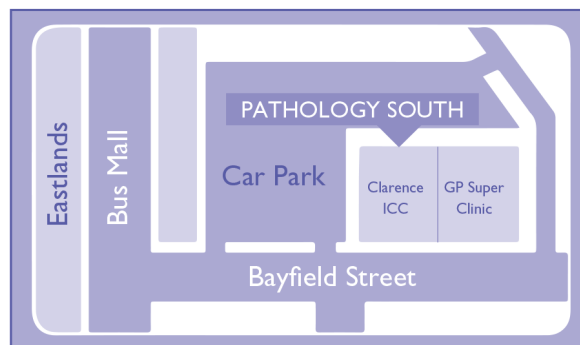
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**Rosny** Clarence Integrated Care Centre • 16 Bayfield Street



Mon-Fri: 8am-12:30pm & 1pm-4pm Phone: 6166 0150 Fax: 6282 0748

**Glenorchy** Glenorchy Health Centre • 404-408 Main Road



Mon-Fri: 8am-12:30pm & 1pm-4pm Phone: 6166 0150 Fax: 6173 0338

**Kingston** Kingston Health Centre • 6 Goshawk Way



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