LABORATORY
Transfusion Medicine Service/Blood Bank

Dartmouth-Hitchcock Medical Center
ONE MEDICAL CENTER DR
LEBANON, NH 03756-0001
(603)-650-2200

Diagnosis:

*All Fields Are Required Including Diagnosis *

MRN#: LOCATION:

FULL NAME:

DOB: SEX: M F

Ordering Provider: #:

Collection Date and Time:

Billing Provider: #:

Patient ID Confirmed & Specimen Collected by - Signature:

Attention Phlebotomist **Your signature above certifies that:**

1) You have made positive identification of the patient named on the request form,
2) This is a specimen collected from that patient, and
3) You have recorded the Blood Lock Code on the sample tube and underlined it.

PRE-OP FOR (DATE OF SURGERY): / / TIME (if known):

☐ **STAT** ☐ **OB Clinic Patient (reflex titer)**

☐ Type and Screen (Lab276)

☐ Type and Screen Neonate (Lab3171)

☐ Type and Screen Same Day (Lab3172)

☐ DAT (direct Coombs test)

☐ Antibody titer:_____

Antibody to titer (if known):_____

☐ Post-Partum RHIG/Fetal Screen

☐ Antenatal RHIG

☐ Post Amnio RHIG

☐ Fetal Cell Enumeration

☐ **Cord Blood** **If a Cord Blood sample, record Mother's name and MRN below:**

Blood Bank Use Only:	Blood Bank Use Only:

PLATELET TESTING:

☐ Platelet/HLA antibody screen

☐ HIT Screen

☐ NAITP work-up

☐ Drug associated PLT antibodies

Drugs to be considered for testing:

_____ _____ _____

Comments:

CHECKBOXES BELOW ARE OPTIONAL AND FOR COLLECTOR'S USE:

Specimen Tube Label:

☐ Dated

☐ Labeled with Patient's Full Name, Medical Record Number, DOB

☐ **Blood Lock Code** recorded and **underlined**

Lab Requisition:

☐ Signed, Dated and Timed

☐ Labeled with Patient's Full Name, Medical Record Number, DOB

Reference: Laboratory Specimen Identification and Labeling Policy
http://policy.hitchcock.org/dotNet/documents/?docid=8798&mode=view