

**LABORATORY**

Transfusion Medicine Service/Blood Bank

Dartmouth-Hitchcock Medical Center

ONE MEDICAL CENTER DR

LEBANON, NH 03756-0001

(603)-650-7207

**Diagnosis:****\*All Fields Are Required  
Including Diagnosis \***

MRN:

LOCATION:

PATIENT NAME:

DOB:

SEX: M F

Collection Date and Time:

Ordering Provider:

Patient ID Confirmed &amp; Specimen Collected by – Print Legibly:

**Attention Phlebotomist** Your name 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.

**PRE-OP FOR (DATE OF SURGERY):** / /

- STAT**       **OB Clinic Patient (reflex titer)**
- Type and Screen                       Renal ABO
- Type and Screen Neonate
- Type and Screen Same Day
- DAT
- Antibody Titer: \_\_\_\_\_
- Cord Blood (ABORh and DAT)  
 Mother's Name: \_\_\_\_\_  
 Mother's MRN: \_\_\_\_\_
- Fetal Cell Screen
- Platelet/HLA Antibody Screen
- HIT Screen
- NAITP Work-up
- Duffy Antigen Type for Chronic Neutropenia
- Prenatal Partner Antigen Type  
 Mother's Name: \_\_\_\_\_  
 Mother's MRN: \_\_\_\_\_  
 Mother's Antibody: \_\_\_\_\_

**Blood Bank Use:**

CHECKBOXES BELOW ARE OPTIONAL AND FOR COLLECTOR'S USE:

**Specimen Tube Label:**

- Dated (hand write if not generated on label)
- Labeled with Patient's Full Name, Medical Record Number, and DOB
- Blood Lock Code** recorded (sticker or written)

**Lab Requisition:**

- Collector Name legibly printed, Dated, and Timed
- Labeled with Patient's Full Name, Medical Record Number, and DOB
- Form is complete with requested test selected and any additional information documented