NAME & ADDRESS OF BLOOD BANK

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Licence No.:-_____

Anti-Human Globulin (Coomb's) Testing Register for Patients
(CM-8)

Sr. No.	Date	Name of Patient	Patient Registration No.	Ward / Unit / Hospital Name	Indication	DAT(Direct Antiglobulin Test)				IAT(Indirect Antiglobulin Test)				Sign
						Method	Positive Control	Negative Control	Result	Method	Positive Control	Negative Control	Result	

Sig. of Supervisor/ Technical Manager:_____