NAME & ADDRESS OF BLOOD BANK

_____

_____

____**Licence No.:-**

BLOOD GROUP COMPATIBILITY & ISSUE (FOR BLOOD BANK) (CM-2a)

PATIENT Registration No:-

INSTRUCTIONS

1. Double check the name as well as the registration no. of the patient on this form and blood sample send for the testing.
2. Request for planned transfusion are acceptable only between_____ (mention time). For emergency cases request for blood and component are accepted anytime.
3. Inform the blood storage center immediately if the proposed transfusion is either cancelled or Postponed.
4. For any emergency, mention the cause of it and be in contact with Blood Bank.

(FOR THE USE OF BLOOD BANK ONLY)

_____ml blood received in EDTA tube and _____ml blood received in plain tube

Blood sample accepted by :- _____ **at _____am/pm on ____/___/20___**

Name of Patient: _____ Reg. No. _____

Ward/ unit/ hospital name: _____

BLOOD GROUPING REPORT

ABO Group of Patient:- _____ RH Grouping of patient : _____

Performed by:- _____

(Name with Signature)

COMPATIBILITY TEST REPORT

Sr. No	Date & Time	Unit No.	Blood group of unit	Type of Component or Whole blood	Result of Cross matching	Method of Cross Matching (saline/AHG/ Bovine albumin /enzyme)	Test performed by Sign (with name)	Date & Time of issue (with sign)

Signature of Quality Manager/Supervisor:-_____

0-4	SLIDE TUBE GEL OTHER	FORWARD ANTI-A / ANTI-A / ANTI-D	REVERCE 'A'CELL/'B'CELL/'D'CELL	BLOOD GROUP & RH.	SIGNATURE