NAME & ADDRESS OF BLOOD BANK

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Licence No.:-_____

Patient Sample Receiving Register (CM-3)

Sr. No.	Date & Time Of Sample Receiving	Blood Bank Request No.	Name of Patient	Age /Sex	Patient Registration No.	Ward / Unit / Hospital Name	Test Requested			Type and Quantity of Blood / Component Required	Sign
							Grouping	Cross Matching	Other Test		

Sig. of Supervisor/ Technical Manager:_____