

REQUEST for BLOOD BANK SERVICES
SYDNEY SOUTH WEST PATHOLOGY SERVICE
 Locked Bag 7090, Liverpool. BC. NSW 1871

PATIENT DETAILS (This section is mandatory)

Patient MRN Ward/Clinic Hospital

Surname First name

Date of Birth / / Sex M / F

Address Suburb / Town Post Code

Tests Requested:

Donor / Recipient

ABO group and antibody screen ☐

Note: Recipients only

Titre: A1 cells ☐

Titre: A2 cells ☐

Titre: B cells ☐

Titre: Donor cells ☐

Attention: Lynette Ackerman / Senior Scientist

Transplant: ABOi Renal ☐ Bone Marrow ☐ Stem Cell/HPC ☐

Sample: Donor ☐ Recipient ☐

Stage	Preliminary ☐	Post-transplant ☐	Date of transplant:
	Pre-apheresis ☐	Post-apheresis ☐	

URGENT – PLEASE SEND SAME DAY TO:

BLOOD BANK – Royal Prince Alfred Hospital

Missenden Road, Camperdown NSW 2050

(If delayed, please refrigerate at 4° C)

Blood Bank specimens must be collected by a Medical Officer or an authorised collector.

The statement below must be signed by the collector and either the patient or a witness to the collection.

Collector's Statement:

Authorised Collector (Print Name): Pager

I certify that this blood was taken from the patient stated and labelled immediately. Sample details have been checked by
 Asking the patient (if possible) 'What is your name and DOB' – and
 Comparing with the ID band.

I have signed the specimen to verify the patient ID. **Collector's Signature:**

Collection Date Time

Patient details must be checked and identical to patient's arm band (if applicable).

Patient / Witness Statement:

Patient / Witness (Print Name)

The blood was taken from me / the patient and details are correct on the form and the specimen (check the spelling and date of birth)

Patient / Witness Signature:

Give a specific reason if patient can't sign (have witness sign instead)

REQUESTING PRACTITIONER DETAILS

Doctor's Surname Initials

Address

..... Phone

DOCTOR'S PROVIDER NO:

SIGNATURE Fax

Date: / / Attending Medical Officer

Laboratory use only:

MEDICARE ASSIGNMENT (Section 20A of Health Insurance Act 1973) – to be completed by the patient offering to assign benefits for services on this form.
 I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner

PATIENT'S SIGNATURE **DATE** / /

PRACTITIONER'S USE ONLY

(Reason patient cannot sign) **MEDICARE NUMBER** ☐

PATIENT STATUS at the time of the service or specimen collection:

A private patient in a private hospital, or approved day hospital facility ☐ A public patient in a recognised hospital ☐ An outpatient of a recognised hospital ☐ A private patient in a recognised hospital ☐

Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised / required by law.