



Important labelling procedures for Blood Bank specimens

Blood banking standards require STRICT ADHERENCE to the labelling requirements below, as dictated by the Australian and New Zealand Society of Blood Transfusion (ANZSBT) and enforced by the National Association of Testing Authorities (NATA).

This includes blood group, antibody screen, group & hold and blood for cross matching.

The sample tube MUST be labelled with:

1. Patient's family name (in full)
2. Patient's given name (in full)
3. UR number and/or Date of Birth
4. Date and time of collection
5. Signature (or initials) of the collector

The request form and sample **MUST MATCH**, including collector's signature (or initials) plus the date and time of collection. Please do not use abbreviations or variations of the patient's name. Samples that do not conform to these labelling requirements will not be processed. O Rh(D) negative units will be issued in the event of urgent blood provision awaiting a valid and appropriately labelled sample.

Please note that if addressograph labels are used:

1. The above labelling procedure still applies
2. The label must be signed by the collector and also include the date and time of collection
3. These labels are not suited to our automated analysers. These samples require manual processing and delays may occur where addressograph labels are used.

An example of correctly labelled referrals and tubes

MELBOURNE PATHOLOGY Head Office and Central Laboratory 103 Victoria Parade Collingwood Victoria 3066 Telephone (03) 9287 7700		Melbourne Pathology Pty Ltd ABN ACN 074 599 139 www.mps.com.au		A2008
Patient Surname: SMITH Given Name: JOHN Address: 10 SMITH ST SMITHVILLE 3000 FAKUR No.:		Doctor Name: DR J BROWN PATH BLK235888051180011 Address: 10 BROWN ST SMITHVILLE 3000 Copy to: Dr Name and Address		
City of Birth: 17/6/51 Sex: M Prep. No.: 97456324 <input type="checkbox"/> Perinatal <input type="checkbox"/> TAC <input type="checkbox"/> WCover <input type="checkbox"/> Repeat		Copy ID No/s: 1. 2.		
Medicare No.: 3456789012 Loc. Code: Hosp. Code: Ward: FF BB MR SF VA MA WC		Specimen Requested: CROSSMATCH 2 UNITS OF PACKED CELLS		
Clinical Notes: FOR RIGHT KNEE REPLACEMENT ON 15/10/08 @ 8am AT SMITHVILLE PRIVATE HOSPITAL NO TRANSFUSION/PREGNANCY IN PAST 3 MONTHS		Tests Requested: CROSSMATCH 2 UNITS OF PACKED CELLS		
Pre Menopausal: <input type="checkbox"/> Post Menopausal: <input type="checkbox"/> Menopausal: <input type="checkbox"/> Post Menopausal: <input type="checkbox"/> Pregnant: <input type="checkbox"/> Hormone Therapy: <input type="checkbox"/>		Patient Status at Date of Service: <input checked="" type="checkbox"/> Private patient in a private hospital or approved day hospital facility <input type="checkbox"/> Hospital patient in a recognised hospital <input type="checkbox"/> Private patient in a recognised hospital <input type="checkbox"/> Outpatient of a recognised hospital <input type="checkbox"/>		
Certify that the pathology specimen accompanying the request was collected from a patient stated above as established by direct enquiry and/or inspection of wrist band.		Signed: J. Brown 15.1.08 1300 hrs		



MELBOURNE PATHOLOGY 103 Victoria Parade, Collingwood Victoria 3066 (03) 9287 7700 www.mps.com.au		Place lab ID here	
Blood and blood products request			
TO BE USED FOR CROSSMATCH/GROUP AND SCREEN/BLOOD PRODUCT ORDERING Patient (Surname, given name, including middle initials): MR SMITH JOHN Address: 10 SMITH ST SMITHVILLE 3000 Postcode: 3000 Tel/mobile no.: 97456324 Date of birth: 17/6/51 Sex: M <input checked="" type="checkbox"/> Pregnant <input type="checkbox"/> wks File/UR no.: 3456789012 Medicare no.:		Referring Doctor (Name and address): DR J BROWN 10 BROWN ST SMITHVILLE 3000 Provider no.: 3000 Copy to ID no/s: 1. 2. Staff ID: Loc. code: Hosp. code: Ward: Pay Cat.	
Your doctor has recommended that you use Melbourne Pathology. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist or other provider, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.		Haematologist advice is available 24 hours, 7 days a week to assist appropriate ordering. Contact via the Melbourne Pathology switchboard on 9287 7700.	
Tests requested (Tick box and complete indication below) <input checked="" type="checkbox"/> Urgent (<2hrs call laboratory blood bank) <input type="checkbox"/> Blood Group and Antibody screen (Group and Screen) <input type="checkbox"/> Crossmatch <input type="checkbox"/> Other blood product Surgical procedure (if relevant): RTKR Hospital: SMITHVILLE ATE Ward: When required: Date: 15.1.08 Time: 0800 am/pm Dr: BROWN Contact no.: 9123.4567		Information required for product supply. (Referrer to complete) Known red cell/antibody: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Previous transfusion reaction: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Previous Bone Marrow Transplant: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Where: Information required for product supply. (Person collecting specimen(s) to complete) Pregnancy in last 3 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Anti-D in last 3 months? (Date if known) 15.1.08 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Transfusion in last 3 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Where: If "Yes" to any of the above questions, the patient is not eligible for extended crossmatch and will need re-collection within 72 hours of scheduled transfusion. I certify that the pathology specimen accompanying the request was collected from the patient stated above as established by direct enquiry and/or inspection of wrist band. Signed: J. Brown Staff ID: 15.1.08 1300 Specimen date and time: 15.1.08 1300 Zero tolerance applies for blood bank specimens Tube type: First pink topped tube. Patient name, DOB, Staff signature, date and time must be identical on tube and referral. Hospital Status: State the patient's status at the time of service or when the specimen was collected. Private patient in a private hospital or approved day hospital facility <input type="checkbox"/> Private patient in a recognised hospital <input type="checkbox"/> Public patient in a recognised hospital <input type="checkbox"/> Outpatient of a recognised hospital <input type="checkbox"/> Patient Account Statement: Your doctor has requested tests, according to clinical need. Some of these may not be eligible for Medicare rebate, for which you will receive an account. Medicare Assignment: (Section 30A of the Health Insurance Act 1973) 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). Patient's signature: J. Smith Date: 15.1.08	
Red blood cells Number of units: 2 Special requirements <input type="checkbox"/> Irradiated <input type="checkbox"/> CMV neg Indication (mandatory completion) <input type="checkbox"/> Hb <80 Hb 80 - 100/L AND <input type="checkbox"/> Acute cardiac event <input type="checkbox"/> Acute cerebrovascular ischaemia <input type="checkbox"/> Active blood loss <input type="checkbox"/> Haemodynamic instability <input type="checkbox"/> Bone marrow failure <input checked="" type="checkbox"/> Pre-operative <input type="checkbox"/> Other (please specify): Platellets (1 bag/adult dose = 4 pooled) Indication (mandatory completion) <input type="checkbox"/> CMV neg <input type="checkbox"/> apheresis <input type="checkbox"/> HLA matched Indication (mandatory completion) Bone marrow failure AND <input type="checkbox"/> Plt <10 x 10 ⁹ /L <input type="checkbox"/> Plt <20 x 10 ⁹ /L and risk factors (fever, antibodies, etc) Surgery/invasive procedure AND <input type="checkbox"/> Plt <50 x 10 ⁹ /L <input type="checkbox"/> Plt <100 x 10 ⁹ /L and high bleeding risk (eg. ocular/neurosurgery) <input type="checkbox"/> Critically ill patient and plt <50 x 10 ⁹ /L <input type="checkbox"/> Massive haemorrhage/transfusion <input type="checkbox"/> Active blood loss and Plt <50 x 10 ⁹ /L <input type="checkbox"/> Other (please specify):		Fresh Frozen Plasma (FFP) Number of units: 2 Special requirements <input type="checkbox"/> cryoprecipitated plasma Indication (mandatory completion) <input type="checkbox"/> Active blood loss AND INR ≥ 2.0 <input type="checkbox"/> Surgery/invasive procedure and INR ≥ 2.0 <input type="checkbox"/> Massive transfusion <input type="checkbox"/> TTP/aHUS <input type="checkbox"/> Other (please specify): Cryoprecipitate (adult dose = 5 units) Number of units: 2 Indication (mandatory completion) <input type="checkbox"/> DIC <input type="checkbox"/> Massive transfusion <input type="checkbox"/> Other (please specify): Fibrinogen deficiency AND <input type="checkbox"/> Active blood loss <input type="checkbox"/> Invasive procedure <input type="checkbox"/> Massive transfusion <input type="checkbox"/> Other (please specify): Prothrombin complex concentrate Dose: 1.5 IU Patient weight: 70 kg Indication (mandatory completion) <input type="checkbox"/> Warfarin reversal <input type="checkbox"/> Other (please specify): Other product (type, dose, indication):	