THE LONDON CLINIC

PATHOLOGY

Transfusion request

PATIENT INFORMATION

*indicates mandatory fields

*TLC unit no. (if known) L

*Title

*DOB dd/mm/yyyy)

*Surname

*Forename(s)

*Gender M F

IP OP DC

Room

*Referrer's full name and contact details / or practice stamp

*Telephone no./ext:

Payment method ☐ Insurance ☐ Embassy ☐ Self-Pay ☐ Sponsor

Payment provider

Member no.

Authorisation no.

Patient's tel no.

Patient's email

Patient's address

Copy of reports to

CLINICAL INFORMATION

A 6mL EDTA specimen handwritten with the patient's forenames(s), surname, date of birth, hospital number, date/time bled and signature is required.

***Clinical details/ reason for transfusion:**

**** Please telephone urgent requests to ext. 3563****

Specimen type(s):

***Date and time of collection:** ___/___/___ @ ___ hrs

Special requirements

☐ Irradiated

☐ Apheresis

☐ HLA matched

☐ Other (please specify)

Previous pregnancy ☐ Yes ☐ No

Patient history

Previous transfusion ☐ Yes ☐ No

Date last transfused ___/___/___

Known antibodies ☐ Yes ☐ No

(please specify)

Investigation/component	Date/time required
☐ Group and screen	___/___/___ @ ___ hrs
☐ DAT	___/___/___ @ ___ hrs
☐ Hold	___/___/___ @ ___ hrs
☐ Crossmatch ___ unit(s)	___/___/___ @ ___ hrs
☐ Platelets ___ unit(s)	___/___/___ @ ___ hrs
☐ FFP ___ unit(s)	___/___/___ @ ___ hrs
☐ Cryo ___ unit(s)	___/___/___ @ ___ hrs
☐ Other (please specify)	___/___/___ @ ___ hrs

Referrer's signature Date ___/___/___

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+44 (0)20 7616 7755

Transfusion Laboratory
+44 (0)20 7616 7763

Outpatient Centre
+44 (0)20 7034 6330

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A **MAIN HOSPITAL**
20 Devonshire Place
London W1G 6BW

B **THE DUCHESS OF DEVONSHIRE WING**
22 Devonshire Place
London W1G 6JA

C **OUTPATIENT CENTRE (PHLEBOTOMY)**
5 Devonshire Place
London W1G 6HL
+44 (0)20 7034 6330

E **PATHOLOGY DEPARTMENT**
116 Harley Street
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E **CONSULTING ROOMS**
116 Harley Street
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+44 (0)20 7935 4444

PHLEBOTOMY OPENING HOURS

Monday to Friday	**Saturday**
8.00am – 7.00pm	9.00am – 1.00pm