Affix Patient ID Label wholly inside this region

Family Name:

Given Name

BTUH Hospital No: Gender:

NHS No: DOB: / /

Affix Patient ID Label wholly inside this region

Basildon and Thurrock University Hospitals NHS
NHS Foundation Trust

Notification of special blood requirements for blood transfusion

Form ID: GNH001B
Version:
Order Ref:
Approved: DD/MM/YYYY
Review By: DD/MM/YYYY
File Under: Health Record\

Do not write on or obscure the barcode

Please state Clinical Diagnosis _____

Rationale for irradiated blood components please tick relevant box(es)

- ☐ Allogeneic bone marrow recipient (from time of conditioning chemo/radiotherapy)
- ☐ Allogeneic bone marrow/stem cell donor
- ☐ Donor/Recipient of autologous bone marrow or peripheral blood stem cell transplant
- ☐ HLA matched donor or first or second degree relative
- ☐ Hodgkin's Disease
- ☐ Aplastic Anaemia
- ☐ Treatment with alemtuzumab (Campath-IH/anti-CD52)
- ☐ Treatment with a purine analogue (eg fludarabine, 2deoxycoformycin, cladribine, clofarabine, bendamustine)
- ☐ Congenital immunodeficiency state
- ☐ Others (please state)

Rationale for CMV negative Blood Products

Any additional information e.g. transfusion at another hospital/documented phenotype

Name of requester (please print and sign)

Date