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SUPER SPECIALITY PAEDIATRIC HOSPITAL AND POST GRADUATE TEACHING INSTITUTE

Sector-30, Noida, G.B. Nagar-201303 (U.P.)
(An Autonomous Institute under Government of Uttar Pradesh)

Department of Transfusion Medicine and Blood Bank

LICENCE NO. U.P./B & BP/2018/03

Request Form for Whole Blood (WB) & Packed Red Blood Cells (PRBC)

- ☐ Property labelled 2 ml EDTA blood should be sent along with this form (0.5 ml EDTA for new born)
- ☐ Any discrepancy between the requisition form and blood sample is UNACCEPTABLE.
- ☐ This form will not be accepted if it is not signed or if any section is left blank.
- ☐ **For Neonatal (<4 months) and Exchange Transfusion please send 3 ml EDTA mother's sample also.**

TMNo:

Patient Name: Anshu CR NO: 9211625003234504 **Age:** 9 yr **Gender:-** (M) **Ward/Bed:** / PHO ward.

Diagnosis: AML **Faculty In charge:** Dr. Nida

ABO/Rh Blood Group (if known): B Rh Positive

Pre Transfusion Haemoglobin value: ∝. gm/dl

Leuko reduction needed yes/no

Indication
- [ ] Bleeding
- [✓] Anaemia
- [ ] Trauma
- [ ] Surgery
- [ ] Dialysis
- [ ] Thalassemia
- [ ] Exchange Transfusion *

Quantity of Blood Units Required: 10 PRBC.

Products	Whole Blood	PRBC	Paediatric PRBC Unit**
Numbers of Units Required (Volume)		10 PRBC.	
Date and Time of Transfusion			

(For Neonatal and Exchange Transfusion please mention the volume required for transfusion.)

☐ **Any relevant past history:**

- O Previous Transfusion [yes/no]; if yes date of last transfusion _____; Any adverse reaction:.....
- O Gravida (in female patients): _____

I certify that, I have personally collected the blood sample after identification of Patient's CR. No and Name. I have explained the necessity of blood transfusion and the risk associated with it to patient/relatives & have taken informed consent.

Please issue blood on urgent/ routine basis:-

[ ] Urgent (immediate spin crossmatch technique) [ ] Routine (AHG cross match technique)

Time: 10 AM AM/PM

Date: 28/9/25

Signature of Nursing Staff

Name Shobha

(BLOCK LETTERS)

Signature of Doctor

Name Dr. Sonal.

(BLOCK LETTERS)

Space to be used by the Department of Transfusion Medicine

Preliminary Blood Group _____

Signature of Medical Technologist

FORWARD (CELL) GROUPING				REVERSE (SERUM GROUPING)			BLOOD GROUP		SIGN
Anti A	Anti B	Anti AB	Anti AD	A Cells	B Cells	O Cells	ABO	Rh	

Auto Control : Positive/Negative

Patients Blood Group _____

Antibody Screening :

Cross Match Records

S.No.	Unit No.	Blood Group	Volume	IS / AHG	SEGMENT No.	Compatible(yes/no)

Notes Overleaf

Date _____ Time _____ AM/PM Signature of Faculty

Signature of Medical Technologist

SSPHPGTI/TM/06/2015/01/01

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Licence No. : U.P./ B & BP/2018/03

Request Form for Components (Plasma/Cryoprecipitate/Platelets/Granulocytes/Stem Cells)

- ☐ Property labelled 2 ml EDTA blood should be sent along with this form.
- ☐ Any discrepancy betwe en the requisition form and blood sample is UNACCEPTABLE.
- ☐ This form will not be accepted if it is not signed or if any section is left blank.

TMNo:-

Patient Name: Prantha CR NO: 9811625003227507 Age: 9 Gender:- M. Ward/Bed: IPD PMO

Diagnosis: AML Faculty In charge: Dr. Nita Haam Blood Group (If known) : B(+).

Type of Components Required: Packed Buffy coat

Indication for Transfusion:

FFP/Plasma	Cryoprecipitate	Platelets
[ ] Haemophilia A/B	[ ] Haemophilia A	**Prophylactic Transfusion no bleeding)**
[ ] Von Willebrand Disease	[ ] Von Willebrand Disease	Indication for transfusion
[ ] DIC	[ ] Factor XIII Deficiency	[ ] Invasive procedure
[ ] Liver Disease	[ ] Afibrinogene	[ ] Fever
[ ] AT-III Deficiency	[ ] Dysfibrinogemia	[ ] Chemotherapy/Radiotherapy
[ ] Deranged Coagulogram	[ ] Deranged Coagulogram	**Therapeutic Transfusion (active bleeding)**
[ ] Burns Shock		Site of bleeding/ Suspected site of bleeding
		[ ] Mucosal (Oral/GIT/Pulmonary/Intracranial/Genitourinary Mucosal Bleeding)

Product	FFP/Plasma	Cryoprecipitate	Platelets (PC/SADP)	Granulocytes/ Stem Cells
Numbers of Units Required (Volume)			10 PBC	
Date and Time of Transfusion				

☐ **Any relevant past history:**

Previous Transfusion, [yes/no]: if yes date of last transfusion 09/09/25 ; Any adverse reaction:-

☐ **Pre Transfusion Values (Mandatory)**

Platelet Count : 0.19 x 10^5/ µL; APTT ____ sec; PT: ____ TLC/ANC 50°/ 0.0

I certify that, I have personally collected the blood sample after identification of Patient's CR. No and Name. I have explained the necessity of blood transfusion and the risk associated with it to patient/relatives & have taken informed consent.

Please issue blood on urgent/ routine basis:-

Time: 11:50 **AM/PM**

Date: 10/09/25

Signature of Nursing Staff

Name ____
(BLOCK LETTERS)

Signature of Doctor

Name Dr. VIVEK K.
(BLOCK LETTERS)

Space to be used by the Department of Transfusion Medicine

Preliminary Blood Group ____ **Signature of Medical Technologist**

Forward (Cell) Grouping				Reverse (Serum Grouping)			Blood Group		Sign
Anti A	Anti B	Anti AB	Anti AD	A Cells	B Cells	O Cells	ABO	Rh	

Patient's Blood Group ____

S.No.	Unit No.	Segment No.	Blood Group	Volume	Technique (IS / AHG)	Compatible	Component

Notes Overleaf

Date ____ Time ____ AM/PM Signature of Faculty Signature of Medical Technologist

SSPHPGTI/TM/06/2015/01/01

Vitals

HR = 68/min
RR = 24/min
SpO_2 = 98% @ RA
Temp = Afebrile
BP = 100/60 mmHg

CVS = S1 S2 ⊕
RS = B/L clear
P/A = soft NT
CNS = conscious, oriented to ⊕, ⊕ & ⊕

Outside investigation

10/04/25 Hb = 5.0 g/dl
TLC = 10.4 × 10³/µL
10/71/3/3/15% (Atypical lymphocyte)
Plt = 24K
PBS RBC = N C N C admixed c microcytic hypochromic cells & few macrocytes, ovalocytes
WBC = leukocytosis (Absolute lymphocytosis c presence of 10% atypical lymphoid cells showing high N/C ratio c irregular nuclear membrane c irregularly clumped to opened up chromatin c 0-1 nucleoli
Plt = Appear reduced in no.

15/04/25
Hb = 5.7 g/dl
TLC = 45.3 × 10³/µl
N/L/M/E/B = 10/C/8/4/8
Blast = 70%
Plt = 35 × 10³/µl

PBS
L = 70% large atypical cells having high N:C ratio c prominent nucleoli (? Blast)
• Smudge cells are also seen

△ ? Acute Leukemia

16/04/2025
weight 22.900 kg

Vital
HR = 62/min
SpO_2 - 96/m
Temp - 98.3°F
B.P - 100/70 mmHg

Adv
CBC
LFT
KFT
Na^+, K^+
PO4, G-6PD
viral marker
Chest x-ray
Ca+, Peripheral smear

Rx
Admit in PHO Daycare
① Inj cefoperazone 800 mg iv BD
② Inj. Furosemide 10 mg IV BD
③ IVF DNS 2000 ml over 24 hourly without KCl
④ Arrange 2 unit RDP.
⑤ Tab. Allopurinol 100 mg ½ tab + ds