

Patient Label

Haematology Request Form

Lab barcode label

Collection Date: _____

Collection & Time: _____

Receive Date & Time: _____

Requesting Doctor

Full name: _____

Signature: _____

Report to: Dr. _____

Telephone No.: _____

Address:

- EDTA Blood
- Sodium Citrate Blood
- Non-Gel Clotted Blood
- Others

General Haematology		General Coagulation	
<input type="checkbox"/>	Complete Blood Count	<input type="checkbox"/>	Prothrombin time & INR
<input type="checkbox"/>	Differential count	<input type="checkbox"/>	APTT
<input type="checkbox"/>	Reticulocyte count	<input type="checkbox"/>	Fibrinogen
<input type="checkbox"/>	Blood Film Examination	<input type="checkbox"/>	Thrombin Time
<input type="checkbox"/>	ESR	<input type="checkbox"/>	D-dimer
Special Haematology		Special coagulation	
<input type="checkbox"/>	Haemoglobin Pattern	<input type="checkbox"/>	Inhibitor screen
<input type="checkbox"/>	Kleihauer Test	<input type="checkbox"/>	Factor assay: <i>circle the factor to be assayed</i> II / V / VII / VIII / IX / X / XI / XII
<input type="checkbox"/>	Malaria parasites	<input type="checkbox"/>	Factor V Leiden
Bone Marrow Examination		<input type="checkbox"/>	Factor VIII Inhibitor
<input type="checkbox"/>	BM Aspirate	<input type="checkbox"/>	Factor IX Inhibitor
<input type="checkbox"/>	Trephine	<input type="checkbox"/>	Von Willebrand Factor
Serology Test		<input type="checkbox"/>	Thrombophilia study
<input type="checkbox"/>	Antibody Screen	<input type="checkbox"/>	Lupus Anticoagulant
<input type="checkbox"/>	Antibody Identification	<input type="checkbox"/>	
<input type="checkbox"/>	Direct Coomb's Test	Miscellaneous	
<input type="checkbox"/>	Cold Agglutinin	<input type="checkbox"/>	Fluid Cell count
<input type="checkbox"/>	ABO/Rh(D) Group*	<input type="checkbox"/>	Semen Analysis
	*I have checked the patient's Identity in the wristband. I have taken blood and labelled the specimen myself. _____		Other:
	(Name & Signature)		

