

STANDARD Component Request

Fields marked as * must be completed

Hospital or NHSBT Use						NHSBT Use			
Hospital Name*	Contact Name*	Date Required*	Time Required*	Delivery Type*	NHSBT Site or Hospital Pulse Code	Received by	Date	Time	Pulse Number
				Routine / Collect / Ad-hoc					

RED BLOOD CELLS								Additional requirements (✓)			
O+	A+	B+	AB+	O-	A-	B-	AB-	STD	CMV-	HEV-	Irr

FROZEN PRODUCTS																	
	O	A	B	AB	HEV-✓		O	A	B	AB	HEV-		O	A	B	AB	HEV-
Adult FFP						Cryo. Single MB					✓	Cryo. Pooled MB					✓
Cryo. Single						Paed. MB FFP (250ml - 300ml)					✓		X	X	X	X	X
Cryo. Pooled						Neonatal MB FFP (50ml - 75ml)					✓		X	X	X	X	X

PLATELETS								Additional requirements (✓)					
Patient Name <i>if required</i>	O+	A+	B+	O-	A-	B-		HT-	CMV-	HEV-	Aph	Irr	Transfusion Date

NEONATAL RED CELLS							Additional requirements (✓)					
Patient Name <i>if required</i>	O+	A+	B+	O-	A-	B-	HT-	CMV-	HEV-	Aph	Irr	Transfusion Date
									✓			
									✓			

NEONATAL PLATELETS							Additional requirements (✓)					
Patient Name <i>if required</i>	O+	A+	B+	O-	A-	B-	HT-	CMV-	HEV-	Aph	Irr	Transfusion Date
									✓			
									✓			

Comments: