Institution	
Dept	Physician
Full Address	PIN
City	
Phone (Lab)	Phone (Physician)

IMMUNOHEMATOLOGY REFERENCE LAB
Phone 033-6605-7607/7601/7603

Patient Name					
Reg no:		Age	Gender ☐ Male ☐ Female	Draw Date	Draw Time
Specimen Type EDTA 12 mL (6 mL vial; 2 Nos)					

Preliminary Results will be mailed to: .... Results needed by Date ....

CLINICAL HISTORY: Diagnosis: .... Hb/Hct :.................................

Indication for Transfusion: **.............................** Total Number of Pregnancies **...........**(Including miscarriages & abortions)

Antibodies: ____

Prior transfusion ☐ Yes ☐ No

Most recent date transfused .... Units Transfused .... ABO/Rh of units ....

Please enclose a copy of your ABO/Rh, DAT, Antibody screen and panel results

☐ Antibody Identification ☐ Antibody titration ☐ DAT negative Workup ☐ Donath Landsteiner

☐ Thermal Amplitude ☐ Other (Please specify) ....

☐ Drug -Dependent RBC antibody study drug ....

☐ Cross match problem

TMC USE ONLY

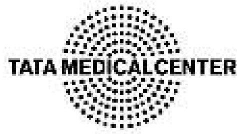
MOLECULAR

Blood group genotyping (20 antigens)

- ☐ **Rh-D**
- ☐ **C/c/C^{w}**
- ☐ **E/e**
- ☐ **K/k**
- ☐ **Fya/Fyb**
- ☐ **Jka/Jkb**
- ☐ **M/N**
- ☐ **S/s**
- ☐ **Dombrock (a)/ Dombrock (b)**
- ☐ **Vel+/Vel**

- All samples must include sample identification clearly marked on each specimen container.
- Proper identification includes full name of Individual, sample collection date, hospital and/or patient identification number and the identification of the individual obtaining the specimen.
- Completed laboratory requisition forms must accompany each sample.
- Blood samples must be packaged to comply with requirements of mail or overnight courier service, if used.

Shipping address: Tata Medical Center, Dept of Transfusion Medicine; 14, MAR (EW), Rajarhat, New Town, Kolkata 700160
Phone no: 033-6605- 7607 / 7601 / 7603



Tata Medical Center

14 MAR (EW), Newtown, Kolkata - 700 160
Phone : +91 33 6605 7000, 7222, Email : info@tmckolkata.com
Website : www.tmckolkata.com

MEDICAL REGISTRATION FORM

(Please enter in CAPITAL Letters)

PATIENT INFORMATION

Title	First Name	Middle Name	Last Name

Father/Husband's Name	Mother's Name

Date of Birth [DD/MM/YYYY]	Age[Y/M/D]	Gender Male/Female/Others	Marital Status Married/Separated/ Single/Widow	Education
Blood Group	Occupation	Nationality	Mother Tongue	

Voter ID/PAN/AADHAR/Driving License Number

ADDRESS DETAILS

Address Line 1			
Address Line 2			
Address Line 3			
Ward		Police Station	
District/City		State	
Country		Pin Code	
Phone No		Alternate Phone number	
E-mail Id		Duration of Stay	

RESPONSIBLE PERSON / KIN DETAILS

Relation		Name	
Contact No.		Emergency Contact No.	

INTERNATIONAL PATIENTS ONLY

Passport Number		Passport Issued at		Passport Expiry Date [DD/MM/YYYY]	
Visa Type		Visa valid from [DD/MM/YYYY]		Visa Expiry Date [DD/MM/YYYY]	

Declaration :

I do hereby declare that all the above information given by me are true to the best of my knowledge. Any modification required to submit a court affidavit for name change and any government identity proof for age, address or next to kin details. My data will be used by Tata Medical Center (TMC) for Clinical usage and patient care. My data will not be used for any other purpose.

SIGNATURE OF THE PATIENT..

DATE[DD/MM/YYYY] ....

FULL NAME OF THE RELATIVE..

SIGNATURE OF THE RELATIVE...

DATE[DD/MM/YYYY] ....

RELATIONSHIP WITH THE PATIENT..