

BHTL-013

**CERTIFICATE IN
PHLEBOTOMY ASSISTANCE
(CPHA)**

**BLOCK
3
LOG BOOK**



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CONTENTS

SR.NO.		PAGE NO.
1.	IDENTIFICATION DETAILS OF THE STUDENT	5
2.	GENERAL INSTRUCTIONS TO STUDENTS	6
3.	OBJECTIVES	6
4.	HOW TO USE THE LOG BOOK	6
5.	DETAILS OF THE POSTING UNDERGONE	7
6.	RECORD OF THE ACTIVITIES CARRIED OUT BY STUDENT	8
6.1	BASIC SKILLS FOR PHLEBOTOMY ASSISTANCE	8
6.1.1	COMMUNICATION WITH PATIENT	8
6.1.2	PROCEDURE FOR HEIMLICH MANOEUVRE	18
6.1.3	RETURN DEMONSTRATION OF THE USE OF COMPONENTS OF A FIRST AID KIT	23
6.1.4	RETURN DEMONSTRATION OF THE USE OF COMPONENTS OF A BLS KIT	24
6.2	RECORDING OF VITAL SIGNS	25
6.3	PREPARATION FOR SAMPLE COLLECTION	48
6.3.1	PROCEDURE FILING UP OF THE TEST REQUISITION FORM (TRF)	48
6.3.2	IDENTIFICATION & DEMONSTRATION OF THE COMPONENTS OF A PHLEBOTOMY COLLECTION TRAY	58
6.3.3	PATIENT PREPARATION AND POSITIONING	59
6.4	COLLECTION AND PACKAGING OF BLOOD SAMPLES	69
6.4.1.	COLLECTION OF BLOOD SAMPLE	69
6.4.2	PACKAGING AND TRANSPORT OF SAMPLES	79
6.4.3	RECORD ATLEAST 25 CASES	89
6.5	POST COLLECTION PROCEDURES	90
6.5.1	SERUM PREPARATION	90
6.5.2	PLASMA PREPARATION	100
6.5.3	RECORD ATLEAST 10 CASES	110
6.6	BLOOD BANK PROCEDURES	111
6.6.1	PREPARATION OF ALIQUOTS	111
6.6.2	DONOR INTERVIEW AND SCREENING	121
6.6.3	DONOR BLOOD COLLECTION	131
6.6.4	POST DONATION CARE AND COUNSELING	141
6.6.5	RECORD ATLEAST 10 CASES	142
6.7	PREVENTION OF INFECTION	152
6.7.1	HYGIENIC HAND WASHING	152
6.7.2	WEARING STERILE GLOVES	152
6.7.3	RECORD ATLEAST 25 CASES	153
7.	DETAILS OF THE DEMONSTRATIONS ATTENDED BY STUDENT	154
8.	DETAILS OF THE TELECONFERENCE SESSIONS ATTENDED BY STUDENT	155
	NOTES BY STUDENT	



1. IDENTIFICATION DETAILS OF THE STUDENT

Photo



Name of the student

Enrollment Number

Address

.....

.....

Email

Mobile



ignou
THE PEOPLE'S
UNIVERSITY

Signature of the Student

Name & Signature of the Academic counselor

2. GENERAL INSTRUCTIONS TO STUDENTS

This log-book is a compulsory component of the Skills for Phlebotomy Assistance (BH TL-013). You are required to maintain all the learning activities that you perform as a part of this course. You will have to maintain log book during self-practice at your work place, supervised practice at Work Centre/ Programme Study Centre. The self practice (Log Book) activities and competency assessment activities will carry 50% weightage i.e., 25 marks for log book and 25 marks for competency assessment. The counselor at the Programme Study Centre shall evaluate log book.

This log-book contains different activities. We have provided a record performaand some blank space for brief recording of activities performed. You are required to fill up the case record proforma at Program Study Centre (PSC)/Skill Development Centre (SDC) / Community Health Centre (CHC) as mentioned. You will fill up the log of activities in the space provided against the respective activities separately. Your supervisor will give remarks & sign.

3. OBJECTIVES

The objectives of the log-book are to:

- enable the counsellors to have a first hand information about the activities performed by you;
- assess the field/academic experience gained by you;
- help you in planning your activities in advance so that you could complete them within the time frame; and
- document your input towards the practical component at Program Study Centre (PSC)/Skill Development Centre (SDC) / Community Health Centre (CHC).

4. HOW TO USE THE LOG BOOK

You may refer to the practical skills mentioned in the programme guide that are expected to be learnt by you during your posting at Program Study Centre (PSC)/Skill Development Centre (SDC) / Community Health Centre (CHC). While performing each skill, you have to record them in this log- book.

Please ensure that whenever you carry out the activities, these should be countersigned by the respective counsellor under whom the activities had been carried out.

5. DETAILS OF THE POSTING UNDERGONE

You should make a list of all your posting with dates as mentioned in the table below. This will help you to keep a tab on your posting and accordingly getting a completion certificate signed at the end of the posting to enable you to appear in the term-end practical examination. Program Study Centre (PSC)/Skill Development Centre (SDC) / Community Health Centre (CHC).

S. No.	Place of Practical Postings	From	To	Signature by Supervisor/mentor	Remarks of the mentor/supervisor
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

6. RECORD OF THE ACTIVITIES CARRIED OUT BY STUDENT

6.1 BASIC SKILLS FOR PHLEBOTOMY ASSISTANCE

6.1.1 COMMUNICATION WITH PATIENT

Introduce yourself: Hello/ Namaskar, I am Mr A. Ensure patient identification: What is your name. [Match the details such as age, sex and ward identification number with the request form]. Explain the procedure: I will now introduce a needle into your vein and draw blood for testing. [Mention the names of the tests to be done and amount of blood to be taken]. Ascertain that the patient understands: did you understand me, do you have any questions, can we start the procedure? Enquire about any allergies to disinfectants, adhesive tape or history of fainting during phlebotomy. Shall we start, if you feel uncomfortable, please let me know immediately.

Case-1

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

.....

.....

.....

IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

.....

.....

.....

Date & time:

Signature of the Student

Remarks of the mentor

Case-2

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

.....

.....

.....

IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

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.....

.....

Date & time:

Signature of the Student

Remarks of the mentor

Case-3

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

.....

.....

.....

IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

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Date & time:

Signature of the Student

Remarks of the mentor

Case-4

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

.....

.....

.....

IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

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.....

Date & time:

Signature of the Student

Remarks of the mentor

Case-5

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

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IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

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Date & time:

Signature of the Student

Remarks of the mentor

Case-6

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

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IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

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Date & time:

Signature of the Student

Remarks of the mentor

Case-7

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

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IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

.....

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Date & time:

Signature of the Student

Remarks of the mentor

Case-8

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

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IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

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.....

Date & time:

Signature of the Student

Remarks of the mentor

Case-9

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

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IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

.....

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Date & time:

Signature of the Student

Remarks of the mentor

Case-10

I. Identification Data:

Name:

Age/Sex:

OPD/Indoor Id number/Address:

II. Patients status: Ambulatory/ differently-abled/ Elderly:

III. Names of tests to be done:

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IV. History of allergy to disinfectants, adhesive tape or history of fainting during phlebotomy

.....

.....

.....

Date & time:

Signature of the Student

Remarks of the mentor

6.1.2 PROCEDURE FOR HEIMLICH MANOEUVRE

Stand behind the person. Wrap your arms around the waist. Tip the person forward slightly. Put the fist of one hand slightly above the naval. Grasp the fist with the other hand. Give a quick, upward thrust, as if trying to lift the person up. Perform between six and 10 abdominal thrusts until the blockage is dislodged. If the obstruction is not relieved and the person becomes unconscious, then standard cardiopulmonary resuscitation (CPR) must be started immediately.

Demonstrate to mentor can do in your colleagues

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Key findings of the case/ person

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.....
.....

List difficulties faced & their solutions while doing Heimlich Manoeuvre

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.....
.....

Date & time

Signature of the Student

Remarks of the mentor

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.....

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Key findings of the case/ person

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.....
.....

List difficulties faced & their solutions while doing Heimlich Manoeuvre

.....
.....
.....

Date & time

Signature of the Student

Remarks of the mentor

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Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Key findings of the case/ person

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.....
.....

List difficulties faced & their solutions while doing Heimlich Manoeuvre

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.....

Date & time

Signature of the Student

Remarks of the mentor

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Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Key findings of the case/ person

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List difficulties faced & their solutions while doing Heimlich Manoeuvre

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Date & time

Signature of the Student

Remarks of the mentor

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Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Key findings of the case/ person

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List difficulties faced & their solutions while doing Heimlich Manoeuvre

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Date & time

Signature of the Student

Remarks of the mentor

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6.1.3 RETURN DEMONSTRATION OF THE USE OF COMPONENTS OF A FIRST AID KIT

Components of a first aid kit Remarks of mentor	Identified & demonstrated the use correctly Yes/No
1. Medical Exam Gloves	
2. Scissors	
3. Tweezers	
4. Adhesive Bandages	
5. Sterile Pads	
6. Triangular Bandage	
7. Safety Pins	
8. Flexible Roller Gauze	
9. Antiseptic applications	
10. Burn Treatment applications	
11. Burn Dressing	
12. Cold Packs	
13. Sterile Water (clean wounds and flush eyes)	
14. Hand Sanitizer	
15. Sodium carbonate (aqueous, 5% solution) in an eye dropper bottle	
16. Acetic acid (aqueous, 5% solution)	
17. Boric acid (saturated) in an eye dropper bottle	
18. Soap water solution in a small bottle	
19. Oral Analgesic	
20. Tissues	
21. Wipes	
22. First Aid Manual/Guide	

6.1.4 RETURN DEMONSTRATION OF THE USE OF COMPONENTS OF A BLS KIT

Components of a BLS kit Remarks of mentor	Identified & demonstrated the use correctly Yes/No
1. CPR mask	
2. Airway kit	
3. Dressing and bandage	
4. Abdominal pads	
5. Trauma dressing	
6. Alcohol wipes	
7. Waterproof tapes	
8. Elastic bandage	
9. Eye pads	
10. BLS booklet	
11. Stethoscope,	
12. Adult BP cuff,	
13. Triangular bandages.	

6.2 RECORDING OF VITAL SIGNS

RECORDING OF PULSE RATE

Collect all the equipment, which include watch or clock with second's hand and recording sheet and pen. Explain the person what you are going to do i.e. checking the pulse. Have a watch which has second's hand in front of you. Wash your hands. Select the site of the pulse (normally radial pulse is taken). Make the person to sit or lie down. You can help him to rest the arm alongside the body with palm facing downwards or fore arm can rest at 90 degree angle across the chest. If the patient is sitting, forearm can be put across the thigh with palm of hand facing downward. Gently place the tips of 1st three fingers of your right hand above the wrist of the person on the side of his thumbs by putting your thumb on other side of wrist until you feel the pulse. If you cannot feel the pulse at the first attempt move your fingers slightly until you can feel it. *Never use your thumb to feel a pulse because there is a pulse in your thumb that you may mistake for the patient's pulse.* Count the number of pulsations (beats for one minute) using a watch with a second's hand. Note the strength and regularity of the beats (i.e. interval between the two pulsations/beats) as you are counting the pulse. Record the pulse in the record sheet.

RECORDING OF RESPIRATORY RATE

Collect all the articles i.e. watch or clock with second's hand, record sheet and pen. Make the patient comfortable. Keep the person/patient in a comfortable position preferably in sitting or lying down position. You can observe (count respiration) after you have counted the pulse so that you will be able to record it accurately. In such situation you can place the arm of the patient across the chest.

Observe/Watch the rise and fall of the chest. Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest). Record the rate of respiration in a record sheet)

RECORDING OF BLOOD PRESSURE

Explain the procedure to the patient. Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed. To begin blood pressure measurement, use a properly sized blood pressure cuff. The length of the cuff's bladder should be at least equal to 80% of the circumference of the upper arm. Wrap the cuff around the upper arm with the cuff's lower edge one inch above the antecubital fossa. Lightly press the stethoscope's bell over the brachial artery just below the cuff's edge. Some health care workers have difficulty using the bell in the antecubital fossa, so we suggest using the bell or the diaphragm to measure the blood pressure. Rapidly inflate the cuff to 180mmHg. Release air from the cuff at a moderate rate (3mm/sec). Listen with the stethoscope and simultaneously observe the sphygmomanometer. The first knocking sound (Korotkoff) is the subject's systolic pressure. When the knocking sound disappears, that is the diastolic pressure (such as 120/80). Record the pressure in both arms and note the difference; also record the subject's position (supine), which arm was used, and the cuff size (small, standard or large adult cuff).

RECORDING OF ORAL TEMPERATURE

Inform the patient about the procedure. Wash hands. After washing hands rinse the thermometer in cold water. Shake thermometer with a quick flip of the wrist till the mercury goes down to 95.5°. Insert the thermometer under the tongue and instruct the patient to close mouth for 3 minutes. Hold the thermometer at the stem with your thumb and finger tips. Read the thermometer by rotating and Bring the thermometer to eye level . Rotate the thermometer until you can see the numbers and long and short lines. Turn the thermometer back and forth slowly until you can see silver (white) or (red) mercury line. Shake down the thermometer after use. Clean the thermometer with soapy swabs from stem to bulb and rinse with water preferably running water under the tap. Put in a disinfectant solution or when thermometer is not in use, you can put it in a closed case after cleaning and drying. Make the patient comfortable. Record temperature.

RECORDING OF AXILLARY TEMPERATURE

Collect all the articles. Explain the procedure to the person. Wash your hands. Rinse and dry the thermometer. Shake down the thermometer. Dry and wipe the axilla with a towel or tissue. Place bulb end of the thermometer in the center of the axilla. Help the patient to place the arm over the chest and hold the thermometer in place. In case the patient is not able to do it himself, you should hold the thermometer and the arm in place. Leave the thermometer for 3-4 minutes. Remove the thermometer. Wipe the thermometer from stem to bulb. Read the thermometer at eye level. Shake down the thermometer. Make the patient/person comfortable. Rinse and wash the thermometer and place it in disinfectant lotion. Wash your hands. Record the reading in record sheet. Report any abnormal temperature.

RECORD OF CASES

Case-1

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

.....

.....

Key findings of the case/ person:

.....

.....

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Site for recording the pulse rate:

Pulse rate per minute:

Interpretation & actions to be taken:

.....

.....

Remarks of the mentor:

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.....

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-2

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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.....

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Key findings of the case/ person:

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Site for recording the pulse rate:

.....

Pulse rate per minute:

.....

Interpretation & actions to be taken:

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.....

Remarks of the mentor:

.....

.....

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

.....

.....

Remarks of the mentor:

.....

.....

.....

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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.....

iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-3

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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Key findings of the case/ person:

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Site for recording the pulse rate:

Pulse rate per minute:

Interpretation & actions to be taken:

.....

.....

Remarks of the mentor:

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.....

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

.....

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Remarks of the mentor:

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.....

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-4

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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Key findings of the case/ person:

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Site for recording the pulse rate:

Pulse rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-5

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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Key findings of the case/ person:

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.....

Site for recording the pulse rate:

.....

Pulse rate per minute:

.....

Interpretation & actions to be taken:

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.....

Remarks of the mentor:

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.....

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

.....

.....

Remarks of the mentor:

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.....

.....

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-6

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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.....

.....

Key findings of the case/ person:

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Site for recording the pulse rate:

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Pulse rate per minute:

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Interpretation & actions to be taken:

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Remarks of the mentor:

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ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-7

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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Key findings of the case/ person:

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Site for recording the pulse rate:

Pulse rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-8

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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Key findings of the case/ person:

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Site for recording the pulse rate:

Pulse rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-9

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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Key findings of the case/ person:

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Site for recording the pulse rate:

Pulse rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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Case-10

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address:

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Key findings of the case/ person:

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Site for recording the pulse rate:

Pulse rate per minute:

Interpretation & actions to be taken:

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Remarks of the mentor:

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ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute:

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Interpretation & actions to be taken:

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Remarks of the mentor:

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iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine:

Systolic pressure:

Diastolic pressure:

Interpretation & actions to be taken:

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Remarks of the mentor:

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iv. Recording temperature

Type of thermometer used Digital/mercury:

Site for recording temperature Oral/Axillary/Anal specify:

Temperature recorded in Centigrade:

Interpretation & actions to be taken:

Signature of the Student

Remarks of the mentor:

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6.3 PREPARATION FOR SAMPLE COLLECTION

6.3.1 PROCEDURE FILING UP OF THE TEST REQUISITION FORM (TRF)

Verify the tests to be collected and the time and date of collection, and to determine whether any special requirements e.g fasting or patient preparation requirements must be met before the venipuncture. Patient's first and last names. Identification number (The identification number may be a hospital-generated number or manual laboratory assigned no.) Patient's date of birth. Patient's address. Name of the doctor who requested the test. Tests requested. Requested date and time of sample collection. Special collection information (such as fasting sample or latex sensitivity).

Case-1

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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.....

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-2

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-3

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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.....

Date & time

Signature of the Student

Remarks of the mentor:

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Case-4

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

.....
.....
.....

Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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.....

Date & time

Signature of the Student

Remarks of the mentor:

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Case-5

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-6

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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.....

Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-7

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-8

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-9

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-10

Patient's first and last names

Identification number

Patient's date of birth

Patient's location

Name of the doctor who requested the test

Tests requested

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Date and time of sample collection

Special collection information (such as fasting sample or latex sensitivity)

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Date & time

Signature of the Student

Remarks of the mentor:

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6.3.2 IDENTIFICATION & DEMONSTRATION OF THE COMPONENTS OF A PHLEBOTOMY COLLECTION TRAY

Components of a phlebotomy collection tray Remarks of mentor	Identified & demonstrated the use correctly Yes/No
1. Evacuated tube system holder	
2. Syringes	
3. Winged blood collection sets	
4. Needles	
5. Needle disposal sharps containers	
6. Evacuated collection tubes	
7. Tourniquet	
8. Gloves	
9. 70 percent isopropyl alcohol, iodine swabs,	
10. chlorhexidine gluconate swabs	
11. gauze pads and Bandages	
12. Slides	
13. Antimicrobial hand gel	
14. Marker pen	

6.3.3 PATIENT PREPARATION AND POSITIONING

Reassure the patient and give a brief explanation of the procedure to the patient, it will make the patient comfortable. Verifying any pretest preparation for e.g fasting or withholding drugs before test. Ask the patient if he or she has a latex sensitivity or any allergic predisposition. Patient seated in a special chair with arm support. The patient's arm should be firmly supported and extended downward in a straight line. Collect all necessary supplies and arrange them near to the patients. Arrange the tubes according to recommended order of draw in a phlebotomy tray. Perform hand sanitization and applying gloves. Apply the tourniquet 3 to 4 inches above the puncture site. Proper Venipuncture site selection. Proper cleansing the site with 70 percent isopropyl alcohol or other antiseptic. Start from the inward to the outward in widening concentric circles spiraling about 2 to 3 inches at the venipuncture site. Repeat the same with a new alcohol swab for particularly dirty skin. Examine the needle for defects, such as a blunted or barbed point, an obstructed lumen, or a bent shaft. Discard the needle or any equipment is defective.

Case-1

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-2

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-3

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-4

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-5

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-6

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-7

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-8

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-9

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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Case-10

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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List difficulties faced & their solutions during patient preparation and positioning

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Date & time



Signature of the Student

Remarks of the mentor:

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6.4 COLLECTION AND PACKAGING OF BLOOD SAMPLES

6.4.1 COLLECTION OF BLOOD SAMPLE

Extend the patient's arm and inspect the antecubital fossa or forearm. Locate a vein of a good size that is visible, straight and clear. Apply the tourniquet about 4–5 finger widths above the venepuncture site and re-examine the vein. Select gauge of a needle (the most frequently used gauges for phlebotomy are 20, 21 and 22). Ask the patient to form a fist so that the veins become more prominent. While performing a phlebotomy, the bevel of the needle must face upward when the needle is inserted into the vein. Introduce the needle into the vein at an angle of 30 degree or below. Once sufficient sample has been collected, remove the tourniquet. Withdraw needle from the vein and simultaneously apply pressure over the venepuncture site with a sterile gauze held by the other hand. Apply firm pressure at the site of venepuncture. The arm must either be extended or raised. It should not be bent at the elbow since there would be a chance of hematoma formation.

Case-1

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-2

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-3

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-4

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-5

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-6

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-7

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-8

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-9

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-10

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address :

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Site of venepuncture:

List difficulties faced & their solutions during collection of samples:

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Date & time

Signature of the Student

Remarks of the mentor

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6.4.2 PACKAGING AND TRANSPORT OF SAMPLES

The samples need to be identified before packaging along with the laboratory requisition. The samples are kept in sample holder with their identification labels towards one side. The samples are placed in a zip lock bag and secured. The samples that are to be transported at room temperature or warmed are separated and packed separately, since a majority of samples are transported in the cold. The hard transport box is selected and ice packs placed on the sides. The ice packs need to be separated from the samples to prevent direct contact. This is done by the use of either thermocol sheets or aluminum foils. The primary packaged samples are then placed in bubble wraps or shredded newspaper or cotton wool and packed in a secondary watertight packing. This secondary packs are then placed in the hard box. The laboratory requisitions for the samples are then placed in another primary packing and placed along with the secondary packs of the samples. The lid of the box is then secured. A label containing the name and address of sender and receiver, telephone number of emergency contact, date and time of sending the packing, total weight and number of samples is then placed on the pack. A bio hazard sticker and an orientation sticker are stuck on the box.

Case-1

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-2

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-3

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-4

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-5

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-6

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-7

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-8

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-9

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-10

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Primary packages for Samples specify:

Secondary packages for Samples specify:

Samples transported in room temperature/ cold specify:

List difficulties faced & their solutions during packaging and transport of samples:

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Date & time:

Signature of the Student

Remarks of the mentor:

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6.4.3 RECORD ATLEAST 25 CASES

Activity	Number of activities carried out	Key points learnt	Signature of mentor
Venipuncture done at median cubital vein site			
Venipuncture done at cephalic vein site			
Venipuncture done at basilic vein site			
Pediatric blood sampling			
Labelling, packaging & transport of samples			

6.5 POST COLLECTION PROCEDURES

6.5.1. SERUM PREPARATION

Collect whole blood in a covered test tube or vacutainer. Allow the blood to clot by leaving it undisturbed at room temperature. This usually takes 15–30 minutes. Separate the serum by centrifuging at 1,000–2,000 x g for 10 minutes. Immediately transfer the liquid supernatant (serum) into a clean polypropylene tube using a pipette. The samples should be maintained at 2–8°C while handling. If the serum cannot analyzed immediately, the serum should be stored in 0.5 ml aliquots at –20°C or lower.

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-6

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-7

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-8

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-9

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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Case-10

Identification Data:

Name

Age/Sex

Indoor Id number/Address

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Blood sample ID

List difficulties faced & their solutions during serum preparation

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Date & time

Signature of the Student

Remarks of the mentor

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6.5.2 PLASMA PREPARATION

Collect whole blood into commercially available anticoagulant containing tubes or vacutainers. Centrifuge for 10 minutes at 1,000–2,000 x g using a refrigerated/ temperature controlled centrifuge for 15 minutes. This removes platelets from the plasma sample. Transfer the liquid supernatant (plasma) into a clean polypropylene tube using a pipette. The samples should be maintained at 2–8°C while handling. If the plasma is not analyzed immediately, the plasma should be should be stored in 0.5 ml aliquots at –20°C or lower.

Case-1

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time

Signature of the Student

Remarks of the mentor

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Case-2

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-3

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-4

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-5

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-6

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-7

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-8

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-9

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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Case-10

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions durin plasma preparation:

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Date & time



Signature of the Student

Remarks of the mentor

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6.5.3 RECORD ATLEAST 10 CASES

Activity	Number of activities carried out	Key points learnt	Signature of mentor
Processing & transport of whole blood samples (EDTA) done			
Processing & transport of Serum/plasma samples done			
Processing & transport of Non-blood samples done -Urine			
Processing & transport of Non-blood samples done —stool			
Non-blood samples done -sputum			
Processing & transport of Non-blood samples done -CSF			
Preparation of aliquots			

6.6 BLOOD BANK PROCEDURES

6.6.1 PREPARATION OF ALIQUOTS

Wear protective gear (cap, mask, gloves etc.) to prevent exposure to specimen and aerosols. Keep all the sample tubes ready (after centrifugation if necessary) along with the requisitions. Identify the number of aliquots to be prepared from a sample depending upon the requisition. Label the aliquot tubes with the name and unique identifier of the patient whose sample is to be transferred. Use printed/ barcode labels wherever available. Without disturbing the sample, using a disposable Pasteur pipette or mechanical pipette with changeable tip to draw the required amount of serum/ plasma and drop it into the aliquot. Cap/ close the lid of the aliquot tightly and secure with a tape when required. Recheck the label of the patient and the required test to be done and store according to the instructions / institutional SOP until further management. Discard the waste in biohazard waste as per institutional protocol

Case-1

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparation:

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Date & time

Signature of the Student

Remarks of the mentor:

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Case-2

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat

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Date & time

Signature of the Student

Remarks of the mentor

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Case-3

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat

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Date & time

Signature of the Student

Remarks of the mentor

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Case-4

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-5

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-6

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-7

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-8

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-9

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-10

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Blood sample ID:

List difficulties faced & their solutions during aliquots preparat:

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Date & time:

Signature of the Student

Remarks of the mentor:

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6.6.2 DONOR INTERVIEW AND SCREENING

Donor registration requires identification (including name, age, sex, address, telephone number, date of birth). The registered donor is then asked to fill a questionnaire.

The donor is then screened for fitness to donate. These criteria are: Age: Minimum: 18 years, Maximum: 65 years. First time donor shall not be over 60 years of age. For repeat donor upper limit is 65 years. Weight: Minimum 45 Kg for 350 ml blood (8-9 ml/Kg) in addition to pilot tubes Minimum 55 Kg for 450 ml blood in addition to pilot tubes. Hemoglobin: $>$ or $=$ 12.5g/dl. Donation interval : 3 months (90 days) for male donors. 4 months (120 days) for female donors. Pulse: 60 –100 beats/ minute with regular rhythm. Blood Pressure: Systolic: 100 – 140 mm Hg; Diastolic : 60-90 mm Hg. Temperature: Afebrile; 37°C / 98.4°F . Skin at phlebotomy site: Should be free from any lesion or scars indicative of IV drug abuse or frequent professional blood donor. If the donor is accepted, the donor is counselled regarding the phlebotomy process and the complications that may occur as a result of donation. The donor then moves into the phlebotomy area after consent.

A donor who does not fulfill the criteria is said to be deferred. If the donor is accepted, the donor is counselled regarding the phlebotomy process and the complications that may occur as a result of donation. The donor then moves into the phlebotomy area after consent. Selection of appropriate bag. Check the bag visually for puncture or discolouration. Check the expiry date of the bag. Write unit number on blood bag and satellite bags, registration form, and pilot tubes with a marker. Write date of collection and expiry on the blood bag/ satellite bags to be mentioned as per format as per DD/MM/YY

Case-1

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-2

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-3

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-4

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-5

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-6

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-7

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-8

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-9

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-10

Name:

Age:

Sex:

ID reference No.:

Weight:

Hemoglobin :

Donation interval:

Pulse:

Blood Pressure:

Temperature:

Skin at phlebotomy site:

Donor status: Accepted/ not accepted give reasons:

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Date & time:

Signature of the Student

Remarks of the mentor:

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6.6.3 DONOR BLOOD COLLECTION

Allow prepared site to dry for at least 30 sec. Dispose swab into waste bin meant for biomedical waste management. After the skin has been prepared it must not be touched again; do not re-palpate the vein at the intended venipuncture site. Inflate the BP cuff / tourniquet to about 80-100 mmHg and perform the phlebotomy. Apply micropore or similar surgical tape to hold the needle in place and cover venipuncture site with a sterile gauze piece. Ask the donor to open and close the fist by squeezing the rubber ball throughout the procedure. Communicate with the donors (especially first time donors) during donation. Never leave the donor unattended during and immediately after the donation. Ensure smooth blood flow and that collection should be completed within 8 to 10 min. As soon as required quantity of blood is collected the blood collection monitor automatically clamps the tube and gives an alarm. Release the blood pressure cuff and apply plastic clamp distal to phlebotomy needle. Withdraw the needle from the arm while applying pressure over the gauze. Ask the donor to apply pressure on the puncture site over the gauze with the other hand for 5 minutes until blood stops oozing. Place the needle inside pilot tube and transfer blood in the pilot tube(s) with same number as on blood bag. Dispose the cut tube and needle into appropriate puncture proof container. Strip blood bag tubing, starting at seal, pushing blood into bag. Invert bag several times to mix blood thoroughly; then allow tubing to refill with anticoagulated blood from the bag. Ask donor to rest on the couch for five minutes and observe for any adverse reaction. Ask donor to proceed to the refreshment area. Seek the help of medical officer in case of any donor reaction. Also learn to identify and manage common donor reactions.

Case-1

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-2

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-3

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-4

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-5

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-6

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-7

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-8

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-9

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-10

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

Date of collection :

Type of Bag used:

Lot number & expiry date of bag:

Gauze of needle used:

Amount of blood collected:

Any adverse reaction:

List difficulties faced & their solutions during donor blood collection:

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Date & time:

Signature of the Student

Remarks of the mentor:

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6.6.4 POST DONATION CARE AND COUNSELING

Post donation care involves : In the refreshment area, the donor is offered some light refreshment and post donation counseling is done here. Have the donor under close supervision for atleast 30 minutes post donation when most of the donor reactions occur. Recheck for veni-puncture site for bleeding. Thank the donor for his thoughtful donation and encourage giving feedback and donating again after 3-4 months

Post donation instructions are: Drink more fluids than usual in the next 4 hours. Do not smoke/drive for half an hour. Do not take alcoholic drinks for at least 6 hours. If there is bleeding from phlebotomy site, apply pressure and raise the arm. If there is feeling of faintness or dizziness, either lie down or sit with head between (knees. If symptoms persist, ask for help, return to the blood bank or consult a doctor. Remove the bandage/band-aid after 4 hours. Restrain from heavy work or exercise for next 24 hours.

Case-1

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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6.6.5 RECORD ATLEAST 10 CASES

Activity	Number of activities carried out	Key points learnt	Signature of mentor
Blood bank procedures- Donor interview and screening carried out			
Donor Venipuncture done			
Donor Blood collections done			
Post donation care and counseling done			

Case-2

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-3

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-4

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-5

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-6

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-7

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-8

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-9

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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Case-10

Identification Data:

Name:

Age/Sex:

Indoor Id number/Address:

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.....

Date of collection:

Rechecked for veni-puncture site for bleeding:

Light refreshments given:

Post donation instructions given:

List difficulties faced & their solutions during post donation period:

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Date & time:

Signature of the Student

Remarks of the mentor:

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6.7 PREVENTION OF INFECTION

6.7.1 HYGIENIC HAND WASHING

Remove all jewellery and watch. Wet your hands under running water. Apply sufficient soap on your hands and wrist; rub your hands to form good lather. Interlace the fingers and rub them thoroughly. Rub the thumbs of both the hands. Rub the palm surface and palm grooves. Thoroughly wash and rinse the hands and wrist under running water. Keep your hands in a downward direction so that water dribbles down. Dry hands and arms thoroughly with clean towel or under the fan.

6.7.2 WEARING STERILE GLOVES

Wash your hands before putting on sterile gloves. Make sure your gloves fit properly for you to wear them comfortably during all patient care activities. If you or your patient is allergic to natural rubber latex, you should choose gloves made from other synthetic materials. Be aware that sharp objects can puncture medical gloves. Always change your gloves if they rip or tear. After removing gloves, wash your hands thoroughly with soap and water or alcohol-based hand rub



6.7.3 RECORD ATLEAST 25 CASES

Activity	Number of activities carried out	Remarks	Signature of mentor
Demonstrate the wearing gloves			
Demonstrate the wearing masks			
Demonstrate the hand washing			
Demonstrate the safe disposal of needles			
Demonstrate the safe collection of waste			
Demonstrate the safe segregation of waste			
Demonstrate the safe transport of waste			

BHTL-013 Skill for Phlebotomy Assistance

Block 1 PRACTICAL MANUAL

UNIT 1 Basic Skills for Phlebotomy Assistance

UNIT 2 Preparation for Sample Collection

UNIT 3 Collection of Blood Sample

UNIT 4 Post Collection Procedures

UNIT 5 Prevention of Infection

Block 2 Check list manual

Block 3 Log book