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|  **Shipping Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shipping Voucher: YYYY-<enter sequential serial number>****Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unique Patient Identifier: \_\_\_\_\_\_\_\_\_\_ Patient Date of Birth \_\_\_\_\_\_\_\_\_\_\_** **dd/mmm/yyyy** **LIS Printout Attached? Y N Packed by (Tech Print/Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date/time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Container Visual Inspection Acceptable? Y N Notified Receiving Hospital? Y N**  **dd/mmm/yyyy hh:mm**  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Product Type** | **\* Unit # / Lot #**(Affix label where applicable | **ABO****Rh** | **Compatibility Status****(if indicated)** | **Visual Insp.** | **Final Disposition** | **Transfused in Transit****by: (MD,RN,Paramedic)** |
| [ ] Red Blood Cell Conc.[ ] Platelet Concentrate[ ] FFP, Thawed[ ] Other |  |  |  | [ ] Acceptable[ ] Not Acceptable | [ ] Transfused in transit [ ] Placed in stock[ ] Discarded[ ] Other |  |
| [ ] Red Blood Cell Conc.[ ] Platelet Concentrate[ ] FFP, Thawed[ ] Other |  |  |  | [ ] Acceptable[ ] Not Acceptable | [ ] Transfused in transit [ ] Placed in stock[ ] Discarded[ ] Other |  |
| [ ] Red Blood Cell Conc.[ ] Platelet Concentrate[ ] FFP, Thawed[ ] Other |  |  |  | [ ] Acceptable[ ] Not Acceptable | [ ] Transfused in transit [ ] Placed in stock[ ] Discarded[ ] Other |  |
| [ ] Red Blood Cell Conc.[ ] Platelet Concentrate[ ] FFP, Thawed[ ] Other |  |  |  | [ ] Acceptable[ ] Not Acceptable | [ ] Transfused in transit [ ] Placed in stock[ ] Discarded[ ] Other |  |

\* Including check digit and source code (affix label to prevent transcription errors)

**PLEASE ADVISE THE SHIPPING HOSPITAL OF THE FINAL DISPOSITION OF THESE UNITS.**

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| **Receipt Information: MUST be completed by Receiving Hospital** |
| **Initials of Receiver:** | **Date/ Time of Receipt:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dd/mmm/yyyy hh:mm** | **Security Seal intact?**🞏 Yes🞏 No | **Packaging:**🞏 **Acceptable**🞏 **Unacceptable** | **Temperature of products on receipt:\_\_\_\_0C**🞏 **Acceptable**🞏 **Unacceptable** | **Time in transit:****\_\_\_\_\_\_\_\_\_\_\_\_\_hrs****(MUST be < 24hrs)** |
| **Correct Site:**  |  |  |  |  |  |

Receiving Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A copy of this form should be kept on file by the shipping hospital until notification of final disposition**