|  |
| --- |
| **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** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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**