**INTER-HOSPITAL REDISTRIBUTION FORM**

Section A and B to be completed by Sending Hospital;

**SECTION A** Voucher #:YYYYMMDD-<Hospital assigned sequential #>

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| --- | --- |
| **Sending Hospital:**  Name:  Address:  City:  Phone #:  Fax #  Email: | **Receiving Hospital:**  Name:  Address:  City:  Phone#:  **Email:** |
| **Shipping Container Visually Inspected:**  **Acceptable  Yes  No** | **Notified receiving hospital by:  Phone  Fax**  **Time: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_**  yyyy/mm/dd |

**SECTION B**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Blood Product to be shipped: | | | | logo 1 FCRP | | | | Factor Concentrate Redistribution Program? Yes  No  | | | | |
| **Product Type** | | **Unit Number/Product Information** | | | | | | | **Visual Inspection**  **√ if OK** | | | **Expiry Date**  yyyy/mm/dd |
| **Facility/Year** | **Unit Number** | | | **Check Digit** | **ABO/Rh** | | **When Sent** | | **When Rec’d** |
| ***Manufacturer*** | ***Lot #*** | | | ***#Vials*** | ***IU/vial*** | |
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|  **See attached LIS printout** | | | Total # units/products shipped in container: | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Please package no more than 1 hour prior to transportation!** | | | | | | | | | **Confirmed Mode of Transportation:**   Air  Courier *(Cargo Truck)*   Courier /Taxi *(passenger compartment)*   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specify | | |
| **Packaged By (print name):** | | | | **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  yyyy/mm/dd  **Time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Copies of charts / logs documenting product storage are not required, provided they are stored within your facility according to IQMH requirements and packed according to appropriate validation protocols. This product has been maintained at:  \_\_\_\_\_\_\_**0C** in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Department    Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |

**SECTION C**

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| **To be filled out by receiving site:** | | | | |
| **Date :**  **Time :** | **Time in transit:**  **\_\_\_\_\_\_\_\_hrs**  **Temperature: \_\_\_\_\_\_\_\_\_°C**  ***(if required)*** | **Security Seal intact: Packaging Acceptable:**  **Temperature acceptable:**  **Delivered to correct facility:**  **Correct product rec’d:**  **Correct Donation/Lot# rec’d:**  **Correct total number rec’d:** |  Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No   Yes  No | **Signature of receiver:**  ** Faxed back to Sending site** |

1. DO NOT use this form if products are transported with a patient for possible transfusion see IM007F
2. Complete one form for each shipping container. Sending hospital: copy completed form and retain for internal records management; send original form with products.