

Emergency Inter-Hospital Transfer of Blood Products Form

Date and Time _____

Origin Hospital _____ Tech _____

Patient Name _____

Products Transferred:

	<u>Unit Number</u>	<u>Product</u>	<u>ABO&Rh</u>	<u>Expiration</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Receiving Hospital _____ Tech _____

Date & Time _____

Temperature of Units _____ Acceptable = Yes or No circle applicable answer

Visual Inspection = Acceptable Unacceptable circle appropriate answer

Please provide the reason if the products are found unacceptable.

Receiving Hospital Blood Bank Technician signature

Fax completed form to Hoxworth Product Management at (513) 558-1534.