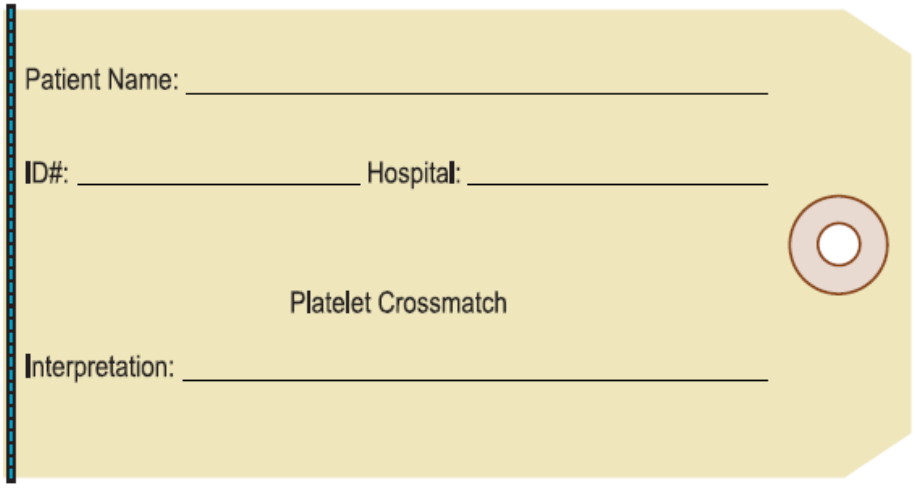
APHERESIS PRODUCT TAG

Color is Manila

FRONT

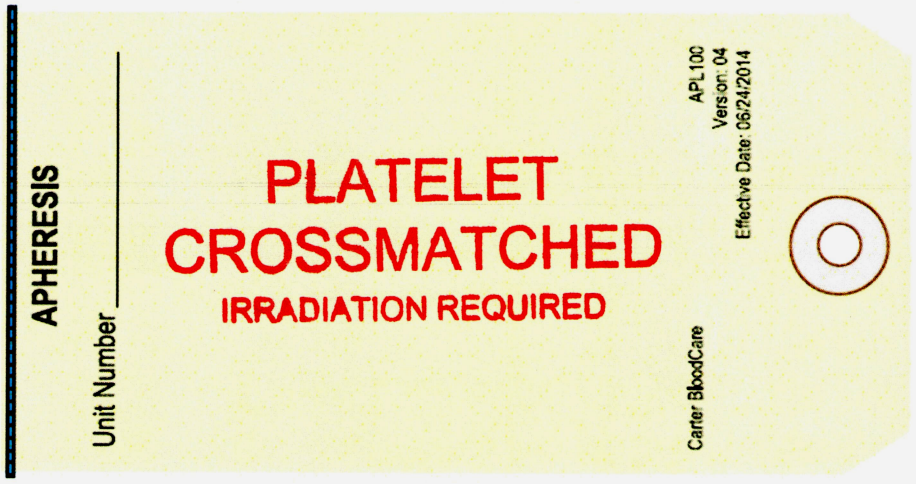
BACK



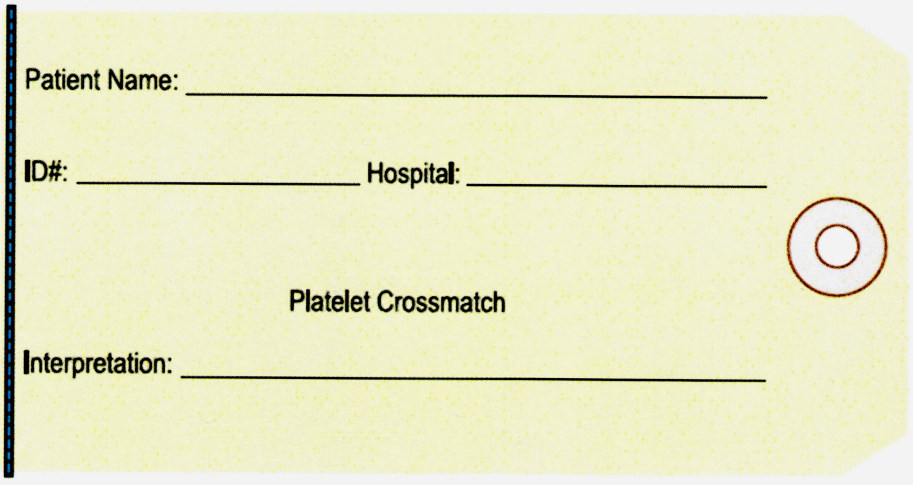
APHERESIS PRODUCT TAG

Color is Manila

FRONT



BACK



CARTER BLOODCARE

2205 HIGHWAY 121 BEDFORD, TX 76021

Facility: Bedford Central Office Client: CBC - Carter Blood Care

Unit #: W035208656565-* Exp. Date/Time: 9/2/08 23:59

Unit Group/Type: O NEG

Component: E4545 AS-3 RED BLOOD CELLS LEUKOCYTES REDUCED

Patient: DOE,JANE BBID: 102

Hospital #: 1022 Case #: 082108DOJA

Patient Group/Rh: O NEG Doctor: Physician,Staff

Crossmatch: COMP Crossmatch Expires: 8/24/08 23:59 By: 6542 8/21/08 13:31

Unit Antigens:

Unit Attributes: Leuko-reduced

The Patient's Name, Hospital Number, Product Type, Unit Number, and additional applicable identifiers were verified in patient's presence prior to transfusion according to institutional policies.

Signature: _____ Signature: _____

Transfusion Record Date: _____

Time From _____ AM/PM To _____ AM/PM

Temperature - Pre _____ Post _____

Amount Transfused _____ Transfusion Reaction: YES NO

If reaction occurs - Stop Transfusion, Initiate Report

Rev. 12/15/2004

CARTER BLOODCARE

2205 HIGHWAY 121 BEDFORD, TX 76021

Facility: Bedford Central Office Client: CBC - Carter Blood Care

Unit #: W035208565656-4 Exp. Date/Time: 8/23/08 23:59

Unit Group/Type: O NEG

Component: E2827 PLATELETS LEUKOCYTE REDUCED

Patient: DOE,JANE BBID: _____

Hospital #: 1022 Case #: 082108DOJA

Patient Group/Rh: O NEG Doctor: Physician,Staff

Crossmatch Not Required By: _____

Unit Attributes: Irradiated Leuko-reduced

The Patient's Name, Hospital Number, Product Type, Unit Number, and additional applicable identifiers were verified in patient's presence prior to transfusion according to institutional policies.

Signature: _____ Signature: _____

Transfusion Record Date: _____

Time From _____AM/PM To _____ AM/PM

Temperature - Pre _____ Post _____

Amount Transfused _____ Transfusion Reaction: YES NO

If reaction occurs - Stop Transfusion, Initiate Report Rev. 12/15/2004

Carter BloodCare

CROSSMATCH ACCOUNT SERVICES REQUEST FORM

Received by Carter BloodCare (Date and Time)

Pick Up Fee (circle one) YES NO

Phone: 817-412-5740 Fax: 817-412-5749

SAMPLE TYPE AND APPROPRIATE SAMPLE LABELING

Required Sample(s) 5 - 15 mls (EDTA) - (NO Serum Separator) Samples were collected using a validated electronic ID system? ☐ Yes ☐ No

Patient Name (Last, First): _____ Sample(s) Collected Date/Time/By: _____

Patient ID: _____ Requesting Facility: _____

Ordering Physician: _____ Blood Bank ID (if app.): _____

Order Status (Circle One)

STAT ASAP ROUTINE

To Be Delivered by Date/Time: _____

Date of Birth: _____ Gender: (Mark One) ☐ M ☐ F ☐ Other: _____

Diagnosis: _____ Blood Bank ID Stickers Included (circle one): Yes No N/A

FOR CBC USE ONLY: Issued to the Distribution Department

DATE	TIME	Clerical Check	Visual Inspection	Tech 1	Tech 2

Transfusion History

Transfused within last 3 months NO YES UNKNOWN If yes, date of last red cell transfusion: _____

Pregnancy History

Number of Pregnancies: _____ Pregnant Now? (circle one) Yes No

RhIG (circle one) NO YES If yes, date of RhIG administration: _____ Date Due: _____

Special Instructions (Circle applicable)

Irradiated Sickle Cell Negative CMV negative

Other (specify) _____

TESTING REQUESTED (check applicable)

_____ Type & Screen and Crossmatch

_____ Type & Screen Only

_____ Blood Type (ABO/RH)

_____ RHIG Evaluation (RH immunoglobulin)

_____ Additional Crossmatched Units (specify number)

_____ Other (specify) _____

PRODUCT REQUESTED (indicate number needed)

_____ LRBC(s)

If applicable (circle one) Autologous Directed

_____ APHERESIS PLATELET(s)

_____ FFP(s)

_____ Cryo(s)

_____ Pack each unit separately

Infusion Sets (indicate number needed) / Misc.

_____ Y type filter (red cells)

_____ Component filter (plasma, platelets, cryo)

_____ Blood Bank Armbands (10 per box; specify number of boxes)

_____ Forms

_____ Other: _____

Pretransfusion Criteria (Check applicable)*

*For compliance with regulatory agencies this section must be completed for any blood component requested.

RED BLOOD CELLS (RBCs)

_____ Current Hgb or HCT*

(Indicate All of the Following that Apply)

_____ Pre-Surgery (Pre-op)

_____ Hemoglobin ≤ 8 g/dl or Hematocrit ≤ 24%

_____ Symptoms of Anemia

_____ Active bleeding/Acute blood loss

_____ Other (specify) _____

PLATELETS (PLTs)

_____ 10^3 cells / ul (Current Platelet Count*)

(Indicate All of the Following that Apply)

_____ Platelet count of 20,000 / ul or less

_____ Platelet count of < 50,000 / ul, bleeding or planned surgery in 24 hours

_____ Platelet dysfunction and bleeding / surgery planned

_____ Platelet count < 50,000 after blood loss

_____ Other (specify) _____

FRESH FROZEN PLASMA (FFP) / CRYO

_____ Active bleeding

_____ Coagulation Deficiency

_____ INR > 1.5

_____ Other (specify) _____

2205 Highway 121
Bedford, Texas 76021
CLIA# 45D0486046

UNCROSSMATCHED OR INCOMPATIBLE PRODUCT RELEASE

☐ UNCROSSMATCHED

This is an acute emergency. The current status of the patient's condition dictates that these units are needed with sufficient urgency to waive the performance of the compatibility testing by Carter BloodCare prior to shipment or administration. The benefits of the product(s) being transfused outweigh the risk(s) involved.

Please sign and fax to the Reference and Transfusion Lab at Carter BloodCare - Fax #817-412-5749

Physician's Signature: _____ Date: _____

Physician's Name Printed: _____ Facility: _____

RN may sign as instructed by physician:_____

(If signed, needs physician signature within 24 hours)

Unit Number	Product code	ABO/Rh	Expiration Date

Patient Name: _____

Patient Account Number: _____

Patient ABO/Rh (if known): _____

R&T Tech: _____ Date: _____

☐ INCOMPATIBLE

The current status of the patient's condition dictates that these units are needed and I acknowledge that the product(s) listed below is/are incompatible with this patient. The benefits of the product(s) being transfused outweigh the risk(s) involved. I understand that close monitoring of this patient for evidence of hemolysis or other transfusion reaction should occur throughout the transfusion period.

Please sign and fax to the Reference and Transfusion Lab at Carter BloodCare - Fax #817-412-5749

Physician's Signature: _____ Date: _____

Physician's Name Printed: _____ Facility: _____

RN may sign as instructed by physician: _____

(If signed, needs physician signature within 24 hours)

Unit Number	Product	ABO/Rh	Expiration Date

Reason for Incompatible Blood Release

☐ Reactivity due to auto antibody

☐ Antibody to a high frequency antigen

☐ Reactivity to a drug antibody

Patient Name: _____

Patient Account Number: _____

R&T Tech: _____ Date: _____

Carter BloodCare

UNTESTED PRODUCT RELEASE

Patient Name	Identification Number	Facility	ABO/RH (if known)

Reason for Product Release:

☐ Checked Test Procedures Not Performed

☐ Collected from a Donor known to be Negative on _____ for Checked Test Procedures
Date

_____ Anti-HIV 1/2
_____ Anti-HTLV I/II
_____ NAT - HIV1/HCV/HBV
_____ HBsAg
_____ STS (Syphilis)
_____ NAT - WNV
_____ Anti-HBc
_____ IAT
_____ NAT – ZIKA
_____ Anti-HCV
_____ CMV
_____ Bacterial Detection (Platelets)
_____ Anti-T.cruzi (Chagas') or Previously Tested

UNIT NUMBER	PRODUCT CODE	PRODUCT DESCRIPTION	ABO/RH

Form Completed by: _____ Date: _____

Current conditions dictate that these units are needed with sufficient urgency to waive the performance of the above tests by Carter BloodCare prior to shipment or administration.

_____ Date: _____
Requesting Physician or Medical Director Signature

HLA MATCHED

Patient _____

ID No. _____

Facility _____

Unit No. _____

HLA MATCHED GRADE _____

IRRADIATION REQUIRED BEFORE INFUSION RTL 422.01

Patient Name: _____

ID#: _____ Hospital: _____

Platelet Crossmatch

Interpretation: _____

APHERESIS

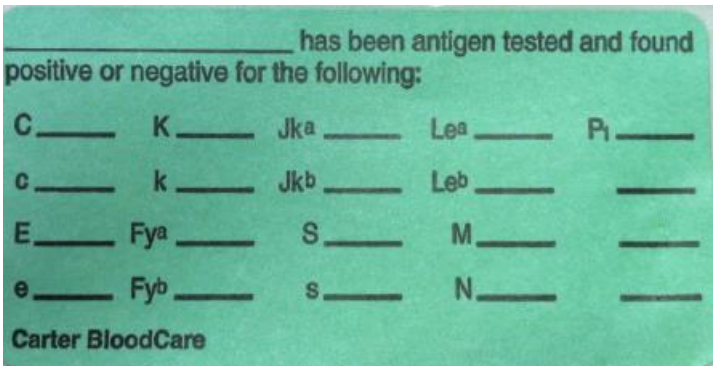
Unit Number _____

PLATELET CROSSMATCHED

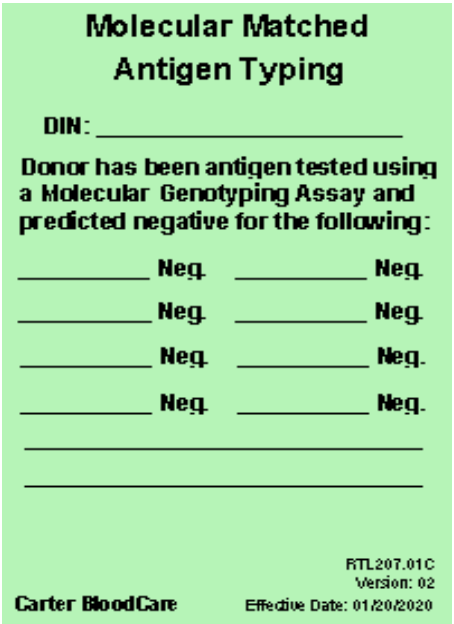
APL.100
Version: 03
Effective Date: 11/11/2008

Carter BloodCare

RTL207.01A Confirmed Antigen Typing (green label)



RTL207.01C Molecular Matched Antigen Typing

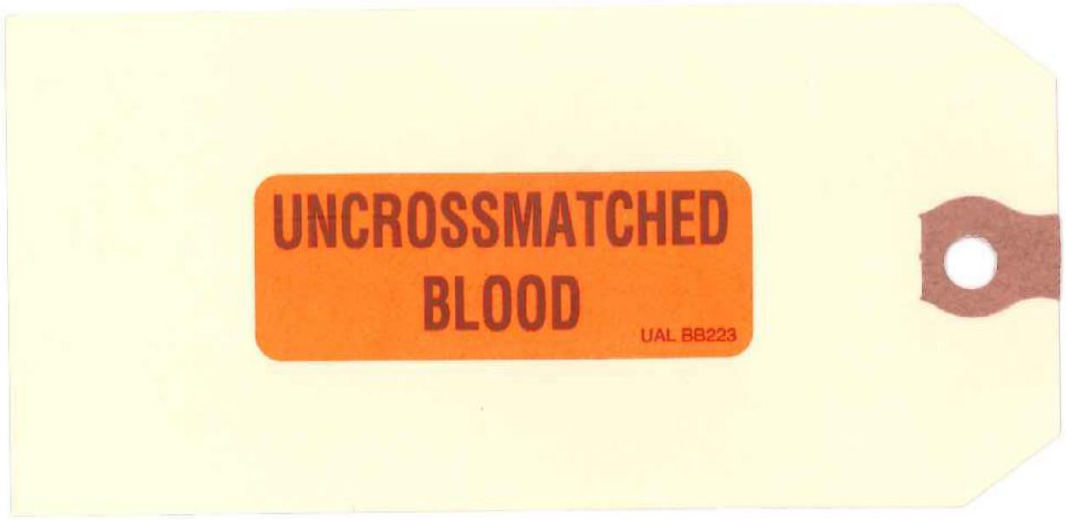


_____ has been antigen tested and found positive or negative for the following:

C_____	K_____	Jk^a _____	Le^a _____	P_1 _____
c_____	k_____	Jk^b _____	Le^b _____	_____
E_____	Fy^a _____	S_____	M_____	_____
e_____	Fy^b _____	s_____	N_____	_____

Carter BloodCare

RTL214.01
Emergency Release Uncrossmatched Blood Label



EMERGENCY RELEASE TIE TAG – "COLLECTED FROM A DONOR KNOWN TO BE NEGATIVE ON"

EXAMPLE: Collected from a donor known to be negative on _____ for

Collected from a donor known to be negative on _____ for	
Anti-HIV-1 / 2	STS
HBsAg	IAT
Anti-HBc	CMV
Anti-HCV	NAT HIV-1/ HCV/ HBV
Anti-HTLV-I/II	NAT WNV
Anti-T. cruzi (Chagas') Negative or Previously Tested	

RTL214.03A
Version: 07
Effective Date: 07/21/2021

EMERGENCY RELEASE TIE TAG – "TESTING NOT PERFORMED"

EXAMPLE: Testing Not Performed

TESTING NOT PERFORMED

Anti-HIV-1 / 2	IAT
HBsAg	CMV
Anti-HBc	NAT HIV-1/ HCV/ HBV
Anti-HCV	NAT WNV
Anti-HTLV-I/II	STS
Bacterial Detection (Platelets)	
Anti-T. cruzi (Chagas')	Crossmatch, if applicable

RTL214.03B
Version: 07
Effective Date: 07/21/2021

HLA MATCHED APHERESIS PRODUCT TAG