Carter BloodCare

INFECTIOUS DISEASE TUBE COLLECTION FORM

FOR TRANSPLANT PROGRAM USE (Collect Samples Monday–Thursday Only)

Facility Name: ❑ UTSW ❑ CMC ❑ COOK ❑ CBC ❑ Other: ____________

Type of Donation: ❑ Autologous ❑ Allogeneic ❑ Other: ____________

If Allogeneic: ❑ Recipient ❑ Donor

Place "Patient Label" here, if applicable.

Sample Collection Date/Time: ____________

Legal Name: ____________ (Last) / ____________ (First) / ____________ (Middle)

Patient Identifier: ____________ ❑ MRN ❑ Driver License ❑ NMDP ❑ Other: ____________

Date of Birth (DOB): ____________ (MM/DD/YYYY) **Gender:** ❑ Male ❑ Female

Home Address: ____________ **Phone Number (Preferred):** ____________

____

IV Fluids in the Past 48 Hours? ❑ Yes ❑ No

- If "Yes," how much volume was infused? _____ mL
- If "Yes," how much volume was infused within 1 hour of blood draw? ____ mL

____________ ____________

Form Filled Out By (Print) Date

CTL Approval by CBC Physician for Possible Hemodilution For Carter BloodCare Staff	Tech Initials/Number	Date/Time	Physician

I give permission for samples of my blood to be tested for markers of infectious diseases including but not limited to HIV 1/2/0, HTLV I and II, hepatitis B, hepatitis C, West Nile virus, syphilis, cytomegalovirus, Chagas Disease and research. I understand if my blood tests positive for certain markers of infection my name will be placed on a confidential list of donors no longer eligible to donate blood. I understand per Federal/State laws the blood center may have to report certain positive tests to the health department. I understand and consent to Carter BloodCare's use and disclosure of results of any tests performed on my blood as is necessary for their operations and as required by law.

____________ ____________

Donor Signature or Legal Representative/Guardian Signature Date

TESTING AND LABELING USE (For Questions Call x-5743 or On-Call Pager 817-824-2574)

NOTE: If sample(s) appears to be a short draw, deliver this form and sample(s) to Cellular Therapy Laboratory. If no one is available, call the on-call pager for Cellular Therapy Laboratory.

1. If a Donation Identification Number (DIN) is not attached, perform the following:
   a. Only process 1 set of tubes at a time.
   b. Verify that donor information on form and on IDM tubes is identical.
   c. Choose a set of ISBT DIN(s).
   d. Attach 1 DIN in the place provided on this form.
   e. Attach 1 DIN to each tube allowing the patient's hospital identification number to be visible.
2. Refer to **TL200.00 Testing Service Contract Sample Processing**.
3. Deliver this form to the Records Audit and Data Entry (RADE) Department for UTSW and CMC samples.
   NOTE: For other facilities, RADE review is not required. Deliver to Cellular Therapy Laboratory.

Attach DIN Number Here

RADE Review, if applicable: ____________ ____________

Employee Initials/Number Date

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INSTRUCTIONS:

For Transplant Program Use

1. Mark name of facility where procedure is performed (i.e., “UTSW,” “CMC,” “COOK,” “CBC” or “Other”).
   - If “Other” is marked, document name of the facility.
2. Mark type of donation (i.e., “Autologous,” “Allogeneic” or “Other”).
   - If “Other” is marked, document name of the requested product.
3. If Allogeneic, mark “Recipient” or “Donor.”
4. Document date and time of sample collection.
5. Document patient’s full legal name (i.e., last, first and middle).
6. Document patient identifier and mark appropriate identifier (i.e., “MRN,” “Driver License,” “NMDP” or “Other”).
   - If “Other” is marked, document name of the identifier used.
7. Document patient’s date of birth (i.e., MM/DD/YYYY).
8. Mark gender (i.e., “Male” or “Female”).
9. Document patient’s home address and preferred phone number.

   NOTE: It is acceptable to use a computer-generated label with demographic information.
10. Mark “Yes” or “No” to indicate if patient has had IV Fluids in the past 48 hours?
    - If “Yes” is marked, document the following:
      - Volume infused (mL)
      - Volume infused within 1 hour of blood draw (mL)
11. Document name of person responsible for collection and for completion of “For Transplant Program Use” section and date completed.
12. Document name of physician approving possible hemodilution (CBC staff’s responsibility to obtain), tech initials/number, date/time and physician’s name.
13. Donor documents acceptance of the terms listed in statement by signing and dating on appropriate lines.

Testing and Labeling Use

1. If samples could be rejected due to short draw, deliver this form and samples to CTS – Tempe.
2. If DIN label is not attached, follow appropriate directions on form.
3. RADE Department staff documents review of form by entering “Employee Initials/Number” and “Date” on appropriate lines.

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