Carter BloodCare

REQUEST FOR PICK UP OF UNITS FOR RETURN FROM CROSSMATCH ACCOUNT CUSTOMERS

Facility: _____ Date/Time: _____

Contact Name: _____ Phone #: _____

FAX to Carter BloodCare @ 817-412-5729

☐ Empty Boxes to Pick Up Quantity: _____

If red blood cell (RBC) products have been maintained at or in:

- 1 – 6°C in facility's blood storage refrigerator and/or transported @ 1 – 10°C, if applicable, document unit information below.
- An unopened shipping box, do not document unit information below.

	Unit #	ABO/Rh	Expiration Date	Comment
1				
2				
3				
4				
5				
6				
7				
8				

While in possession of the RBCs listed, or the packlist referenced, units were:

☐ Stored @ 1 – 6°C and/or transported @ 1 – 10°C, if applicable in accordance with Carter BloodCare standards and have not been modified or manipulated by this facility in any way.

OR

☐ Maintained in an unopened, sealed Carter BloodCare Shipping Box, protected from extreme heat or cold.

Packlist #: _____

Time of Shipment: _____ (refer to top-right header of packlist)

Receipt of units by Carter BloodCare must be within 24 hours of "Time of Shipment" documented above.

Facility Representative: _____ Date: _____

Carter BloodCare HSR: _____ Date/Time: _____

Component Temperature: _____°C

Carter BloodCare Employee ID#: _____ Date/Time: _____

Carter BloodCare

REQUEST FOR PICK UP OF UNITS FOR RETURN FROM CROSSMATCH ACCOUNT CUSTOMERS

Directions for Completing Request for Pick Up of Units for Return

Customer (Facility)

1. Document institution name in the space marked "Facility."
2. Document the date and time the form is sent to Carter BloodCare Distribution.
3. Document facility contact name.
4. Document facility contact telephone number.
5. If boxes are needed to be picked up along with the unit(s) for return, mark "Empty Boxes to Pick Up" box. Document quantity.
6. Complete the table, if applicable.
   - If units have been maintained in a 1 – 6°C continuously monitored refrigerator, document unit information in table.
   - If the units have been maintained in an unopened, sealed Carter BloodCare (CBC) Shipping Box, do not document unit information in table.
7. Facility representative:
   a. Mark appropriate box for how the units were stored.
      NOTE: Units maintained in a CBC Blood Shipping Box must not be subjected to temperature extremes at any time while in possession of the institution.
   b. Document packlist #.
   c. Document time of shipment.
   d. Sign and date the form.

Carter BloodCare Hospital Service Representative (HSR)

Upon arrival at the facility, CBC HSR documents signature, date and time of the pick-up.

NOTE: The signed form must accompany the units or shipping box being returned.

Carter BloodCare Staff

1. Upon arrival of returned units, ensure form has been properly completed by the facility. Verify all documented unit information matches the actual units being returned, or that the packlist number and shipping time have been documented when units were sealed in CBC Blood Shipping Box.
2. After arriving at CBC Distribution Department, perform a temperature test on any units returned in an unopened, sealed CBC Blood Shipping Box. Refer to DP400.12 Performing a Temperature Check or Test. Document the temperature, employee ID#, date and time in the spaces provided.
3. Attach this form to the LifeTrak Return printout after electronically returning the units. DPF300.03 Hospital Report of Returned Blood Components to Carter BloodCare is not required.

Carter BloodCare

TRANSFUSING FACILITY MEDICAL DIRECTOR CHECKLIST

Facility:	
Address:	
Medical Director:	
Medical Director Phone #:	Medical Director Email:

Transfusing Facility Medical Director Checklist	
Written procedures are approved and staff are trained and continue to be trained for the following:	
Procedure	**Comments**
Patient identification Includes validated electronic patient identification or submission of a 2nd sample collected at a time different from the 1st sample, including a new verification of patient identification.	
Specimen collection	
Specimen labeling	
Return and re-issue of blood components	
Blood administration and annual competency of personnel	
Recognition and reporting of infectious and noninfectious adverse events	
Transfusing facilities shall have a peer-review program that monitors and addresses transfusion practices for all categories of blood and blood components. The following shall be monitored:	
Monitored Transfusion Practices	**Comments**
Ordering practices*	
Patient identification Includes validated electronic patient identification or submission of a 2nd sample collected at a time different from the 1st sample, including a new verification of patient identification.	
Sample collection and labeling**	
Infectious and noninfectious adverse events	
Near-miss events	
Usage and discard*	
Appropriateness of use*	
Blood administration policies	

* = Carter BloodCare provides available data on a quarterly basis.

** = Carter BloodCare provides specimen rejection data on a monthly basis.

Please refer to Carter BloodCare Crossmatch Services Manual, sections: 9, 10 and 11.

By signing, you are agreeing to abide by AABB standards and comply with peer-review recommendations.

Signature required

Medical Director: _____ Date: _____

Carter BloodCare

INITIAL AND ANNUAL STORAGE CHECKLIST

Facility:	
Address:	
Main Facility Phone #:	Main Facility Fax #:
Laboratory Phone #:	Laboratory Fax #:
Primary Contact:	Title:
Director of Nursing:	Title:
Administrator:	Title:
Medical Director:	Medical Director Phone #:
Medical Director Email:	Medical Director Fax #:
Blood Bank Refrigerator? ☐ Yes ☐ No	
Centralized Temperature Monitoring System (CTMS)? ☐ Yes ☐ No	
New Account In-Service:	Annual Inspection Date:
Crossmatch Service Manual Delivered:	

Yes	No	Facility SOPs and Policies Established	Comments
		Monitoring Requirements	
		Storage devices for blood components shall have audible alarms	
		Remote alarm monitoring 24/365 if facility is not staffed at all times	
		For storage of blood components, the temperature shall be monitored continuously and documented at least every 4 hours	
		The alarm shall be set to activate under conditions that allow proper action to be taken before blood components reach unacceptable conditions	

		Return and re-issue of blood components—blood components can only be re-issued if the following criteria are met:
		• Primary container has not been opened
		• Appropriate temperature has been maintained
		  ○ Red cells and thawed plasma at 1°C – 10°C
		  ○ Platelets and thawed cryoprecipitate at 20°C – 24°C
		• Records indicate that the blood components have been inspected and they are acceptable for re-issue to patient care areas	

INITIAL AND ANNUAL STORAGE CHECKLIST

Yes	No	Facility SOPs and Policies Established	Comments
Corrective Action Policies (Process in which activation of the alarm shall initiate immediate action, investigation and appropriate corrective action[s].)			
		Process for the management of blood components when temperature cannot be maintained	
		Process to review the temperature chart and/or CTMS records on a weekly basis for temperature deviations	
		Documentation of the reason(s) for any temperature deviations and corrective action(s) should be included in the policy	

Quality Control					
CTMS			**Chart Recorder**		
Yes	**No**		**Yes**	**No**	
Daily					
		Thermometer present in refrigerator			Thermometer present in refrigerator
		Verification that the alarm system is powered on			Verification that the alarm system is powered on
					Log to document daily temperatures
Weekly					
		Log to document review of temperatures			Chart is replaced every 7 days
					Chart includes start / stop dates
					Chart is labeled with facility name, storage device ID / name and personnel initials
Quarterly					
		Verify and document electrical source for the alarm system to ensure alarm is functional (battery check or independent circuit check)			Verify and document electrical source for the alarm system to ensure alarm is functional (battery check or independent circuit check)
		Perform alarm activation testing for low and high alarms			Perform alarm activation testing for low and high alarms
		Set low and high alarms to activate prior to reaching a critical storage temperature, e.g., low 1.5°C; high 5.5°C			Set low and high alarms to activate prior to reaching a critical storage temperature, e.g., low 1.5°C; high 5.5°C

INITIAL AND ANNUAL STORAGE CHECKLIST

Quality Control					
CTMS			Chart Recorder		
Yes	No		Yes	No	
Annually					
		Temperature comparison performed between manual thermometer to CTMS Acceptable variance is ± 1°C			Temperature comparison performed between manual thermometer to chart recorder Acceptable variance is ± 1°C
		Thermometers are calibrated against NIST-certified or traceable standard or replaced annually			Thermometers are calibrated against NIST-certified or traceable standard or replaced annually

Carter BloodCare Review: _____ Date: _____

Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES
IMMUNOHEMATOLOGY FINAL REPORT

Patient Name:		Sample Collection Date & Source:	
ID Number:		Date Request Received:	
Requesting Facility:		Test (s) Requested:	
Ordering Physician:		Patient Date of Birth & Gender:	

ABO/RH TYPE

ABO		Rho (D)		RH Phenotype	RH2	RH3	RH4	RH5	Probable Rh-hr
					C	E	c	e	Genotype

ADDITIONAL RED CELL ANTIGEN TYPE

MNS1	MNS2	MNS3	MNS4	KEL 1	KEL2	FY1	FY2	JK1	JK2	P1PK1	LE1	LE2							
M	N	S	s	K	k	Fy(a)	Fy(b)	Jk(a)	Jk(b)	P_1	Le(a)	Le(b)							

DIRECT ANTIGLOBULIN TEST

POLY		IgG		C3		ELUATE	

ANTIBODY(IES) IDENTIFIED

		LISS		PeG	Gel	Solid Phase	Comments
		37˚C	IgG	IgG	IgG	IgG	
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						

ADDITIONAL DETAILS

TRANSFUSION RECOMMENDATIONS

Testing performed by:		Date & Time:	
Record reviewed by:		Date & Time:	
Report reviewed by the Medical Director on:	L.Sutor, MD G.Paranjape, MD W.Crews, MD T. Nishimoto, MD F. Compton, MD	Date:	

"+m" = Microscopic "+w" = Weakly Positive NT = Not Tested Pre/Prev = Previous

Carter BloodCare
2205 HWY 121
Bedford, TX 76021
(p)817-412-5740
(f)817-412-5749
CLIA#45D0486046
AABB IRL #95

Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES

IMMUNOHEMATOLOGY FINAL REPORT

Patient Name:	PATIENT, PATIENT	**Sample Collection Date:**	09-23-2020 07:00
ID Number:	1111	**Date Request Received:**	09-23-2020 12:57
Requesting Facility:	Carter BloodCare	**Test(s) Requested:**	Type and Screen ONLY
Ordering Physician:	Physician, Staff	**Patient DOB/Gender:**	01-01-1980/Male

ABO/RH TYPE

ABO	O	**Rho (D)**	Positive	**RH Phenotype**	**RH2**	**RH3**	**RH4**	**RH5**	**Probable Rh-hr**
					C	E	c	e	Genotype
					Neg				

ADDITIONAL RED CELL ANTIGEN TYPE

MNS1	**MNS2**	**MNS3**	**MNS4**	**KEL1**	**KEL2**	**FY1**	**FY2**	**JK1**	**JK2**	**P1PK1**	**LE1**	**LE2**							
M	N	S	s	K	k	Fya	Fyb	Jka	Jkb	P1	Lea	Leb							

DIRECT ANTIGLOBULIN TEST

POLY:	0 (Negative)	**IgG:**		**C3:**		**ELUATE:**	

ANTIBODY(IES) IDENTIFIED

		LISS		**PeG**	**Gel**	**Solid Phase**	**Comment**
		37°C	IgG	IgG	IgG	IgG	
Anti-C	Reactive by				X		

ADDITIONAL DETAILS

TRANSFUSION RECOMMENDATIONS

If transfusion therapy is indicated, give crossmatch compatible red blood cells that are negative for the C antigen.

Testing performed by:	Boyd, Pamela	**Date & Time:**	09-23-2020 12:58
Record reviewed by:	GCBoyd	**Date & Time:**	9/23/20
Report reviewed by the Medical Director on:	L. Sutor MD; G.Paranjape MD; W.Crews MD; T.Nishimoto MD; F. Compton, M.D	**Date:**	

"+m" = Microscopic; "+w" = Weakly Positive; NT = Not Tested; * = Historical test result

Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES

PRELIMINARY REPORT

Additional testing and review may be in progress.

Patient Name:		Sample Collection Date & Source:			
ID Number:		Date Request Received:			
Requesting Facility:		Test (s) Requested:			
Ordering Physician:		Patient Date of Birth & Gender:			

ABO/RH TYPE

ABO		Rho (D)		RH Phenotype	RH2	RH3	RH4	RH5	Probable Rh-hr
					C	E	c	e	Genotype

ADDITIONAL RED CELL ANTIGEN TYPE

MNS1	MNS2	MNS3	MNS4	KEL 1	KEL2	FY1	FY2	JK1	JK2	P1PK1	LE1	LE2							
M	N	S	s	K	k	Fy(a)	Fy(b)	Jk(a)	Jk(b)	P_1	Le(a)	Le(b)							

DIRECT ANTIGLOBULIN TEST

POLY		IgG		C3		ELUATE	

ANTIBODY(IES) IDENTIFIED

		LISS		PeG	Gel	Solid Phase	Comments
		37˚C	IgG	IgG	IgG	IgG	
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						
Anti-	Reactive by						

ADDITIONAL DETAILS

TRANSFUSION RECOMMENDATIONS

Testing performed by:		Date & Time:		

"+m" = Microscopic "+w" = Weakly Positive NT = Not Tested Pre/Prev = Previous

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RTF102.04
Version: 10
Effective Date: 04/02/2018

Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES

PRELIMINARY REPORT

Additional testing and review may be in progress.

Patient Name:		Sample Collection Date & Source:		
ID Number:		Date Request Received:		
Requesting Facility:		Test (s) Requested:		
Ordering Physician:		Patient Date of Birth & Gender:		

ADDITIONAL DETAILS

TRANSFUSION RECOMMENDATIONS

Testing performed by:		Date & Time:		

"+m" = Microscopic NT = Not Tested Pre/Prev = Previous

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Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES

PRELIMINARY REPORT

Additional testing and review may be in progress.

Patient Name:	PATIENT, PATIENT	**Sample Collection Date:**	09-23-2020 07:00
ID Number:	1111	**Date Request Received:**	09-23-2020 12:57
Requesting Facility:	Carter BloodCare	**Test(s) Requested:**	Type and Screen ONLY
Ordering Physician:	Physician, Staff	**Patient DOB/Gender:**	01-01-1980/Male

ABO/RH TYPE

ABO	O	**Rho (D)**	Positive	**RH Phenotype**	**RH2**	**RH3**	**RH4**	**RH5**	**Probable Rh-hr**
					C	E	c	e	Genotype
					Neg				

ADDITIONAL RED CELL ANTIGEN TYPE

MNS1	**MNS2**	**MNS3**	**MNS4**	**KEL1**	**KEL2**	**FY1**	**FY2**	**JK1**	**JK2**	**P1PK1**	**LE1**	**LE2**							
M	N	S	s	K	k	Fya	Fyb	Jka	Jkb	P1	Lea	Leb							

DIRECT ANTIGLOBULIN TEST

POLY:	0 (Negative)	**IgG:**		**C3:**		**ELUATE:**	

ANTIBODY(IES) IDENTIFIED

		LISS		**PeG**	**Gel**	**Solid Phase**	**Comment**
		37°C	IgG	IgG	IgG	IgG	
Anti-C	Reactive by				X		

ADDITIONAL DETAILS

TRANSFUSION RECOMMENDATIONS

If transfusion therapy is indicated, give crossmatch compatible red blood cells that are negative for the C antigen.

Testing performed by:	Boyd, Pamela	**Date & Time:**	09-23-2020 12:58

"+m" = Microscopic; "+w" = Weakly Positive; NT = Not Tested; * = Historical test result

Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES

CROSSMATCH ACCOUNT REPORT

Patient Name:		Sample Collection Date:		
ID Number:		Date Request Received:		
Requesting Facility:		Test (s) Requested:		
Ordering Physician:		Patient Date of Birth & Gender:		

Red Cell Typing:

ABO _____ $Rh_o(D)$ _____

Antibody Screen Result:

NEG _____

POS _____

Crossmatched Unit(s):

Direct Antiglobulin Test (DAT):

Poly _____

IgG _____

C3 _____

Testing performed by:		Date & Time:		

N/A, NA = Not Applicable NT = Not Tested

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Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES

CROSSMATCH ACCOUNT REPORT

Patient Name:		Sample Collection Date:	
ID Number:		Date Request Received:	
Requesting Facility:		Test(s) Requested:	Type & Screen
		Patient Date of Birth & Gender:	
Ordering Physician:	Physician, Staff	Accession Number:	

Red Cell Typing:

ABO _____ **$RH_O(D)$** _____

Antibody Screen Result:

NEG _____

POS _____

Crossmatched Unit(s):

Testing performed by:		Date & Time:	

N/A, NA = Not Applicable NT = Not Tested

Carter BloodCare
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CLIA#45D0486046
AABB IRL #95

RTF 102.07D
Version 03
Effective Date: 04/16/2018

Carter BloodCare

2205 Hwy 121, Bedford, TX 76021

Reference and Transfusion Service

Crossmatch Account Report

Facility: Carter BloodCare

Patient Name: PATIENT, PATIENT **DOB:** 01-01-1980 **Gender:** Male

Physician Name: Physician, Staff **Medical Record #:** 1111 **Armband #:**

Specimen(ID:BE0002050) Collection Date/Time: 09-23-2020 07:00 **Crossmatch Exp. Date/Time:** 09-26-2020 23:59

ABO/Rh: O Pos

Antibody Screen Results: Pos

DAT Result:

Performed By: Boyd, Pamela **Performed Date/Time:** 09-23-2020 12:58

Carter BloodCare: 2205 HWY 121, Bedford, TX 76021. (Phone) 817-412-5740, (Fax) 817-412-5749. CLIA#: 45D0486046. AABB: IRL #95

Carter BloodCare

Request ID: RQ2009231321126, MRN: 8999, Carter BloodCare

Patient ID: | Name: PATIENT, PATIENT | DOB: 09-01-1950 | Gender: Female

Specimen Rejection Report

Patient Name	MRN	Facility	Specimen Collected and Received
PATIENT, PATIENT	8999	Carter BloodCare	Date/Time Collected: 09-23-2020 07:00, Date/Time Received: 09-23-2020 13:21
Person Notified	**Date/Time Notified**	**Notified By**	**Reason for Rejection**
BOB	09-23-2020 13:21	Boyd, Pamela	No Date on Sample
Additional Reason for Rejection			

Request Details

Patient Information

Patient Name	DOB	Gender	MRN	Physician	Facility	Armband ID	Blood Bank ID Stickers
PATIENT, PATIENT	09-01-1950	Female	8999	Physician, Staff	Carter BloodCare		

Pregnancy History:	Has the patient ever been pregnant? Unknown
Transfusion History:	
Diagnosis:	
Medication:	
Patient Comment:	

Specimen Information

No Specimen received:	No
Specimen was collected using an electronic ID system or another validated process to reduce the risk of patient misidentification.:	Yes

Specimen ID	Collection Date/Time	Specimen Collected By	Received Date/Time	Number of Tubes	Pre-Admit	Surgery Time
	09-23-2020 07:00	BOB	09-23-2020 13:21	1	No	
Specimen Comment:						