

**SECTION I:**

CONTENTS:

Shipment Invoice #:

To (Hospital/RHA):	Shipping Ambient Temp: <input type="checkbox"/> 4°C or greater <input type="checkbox"/> less than 4°C
From (Hospital/RHA):	

**Blood Components:**

Unit Number	ABO/Rh	Modifiers	Visual Inspection √ if OK and Initials R if Rejected and Initials				Total # of units shipped
			Issued		Received		
			√ / R	Init	√ / R	Init	

**Blood Products:**

Unit number	Lot Number	Expiry Yyyy/mm/dd	Amount (vial size and number of vials)	Visual Inspection √ if OK and Initials R if Rejected and Initials			
				Issued		Received	
				√ / R	Init	√ / R	Init

**SECTION II:**

<b>Packaged By:</b>  _____ Print Name  _____ Signature	<b>Date:</b> _____ yyyy/mm/dd  <b>Time:</b> _____ hhmm (24 hr clock)	<b>Mode of Transportation</b> <input type="checkbox"/> Air <input type="checkbox"/> Courier <input type="checkbox"/> Taxi <input type="checkbox"/> Other: _____
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**SECTION III:**

To be completed by receiving hospital

<b>Initials of Receiver:</b>  _____	<b>Date and Time of Receipt:</b> <b>Date:</b> _____ yyyy/mm/dd  <b>Time:</b> _____ hhmm (24 hr clock)	<b>Security device in place?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Packaging:</b>  <input type="checkbox"/> Acceptable  <input type="checkbox"/> Unacceptable	<b>Temperature of products on receipt: _____°C</b>  <input type="checkbox"/> Acceptable  <input type="checkbox"/> Unacceptable	<b>Time in transit:</b>  _____ hr  _____ min
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Additional Comments: \_\_\_\_\_

**Instructions for hospitals:**

1. DO NOT use this form if products are transported with a patient for possible transfusion.
2. Complete one form for each shipping container.
3. Copy completed form for internal records management.
4. Send original form with products.
5. All information must be completed for products to be used. Hospital policy will determine disposition of products.