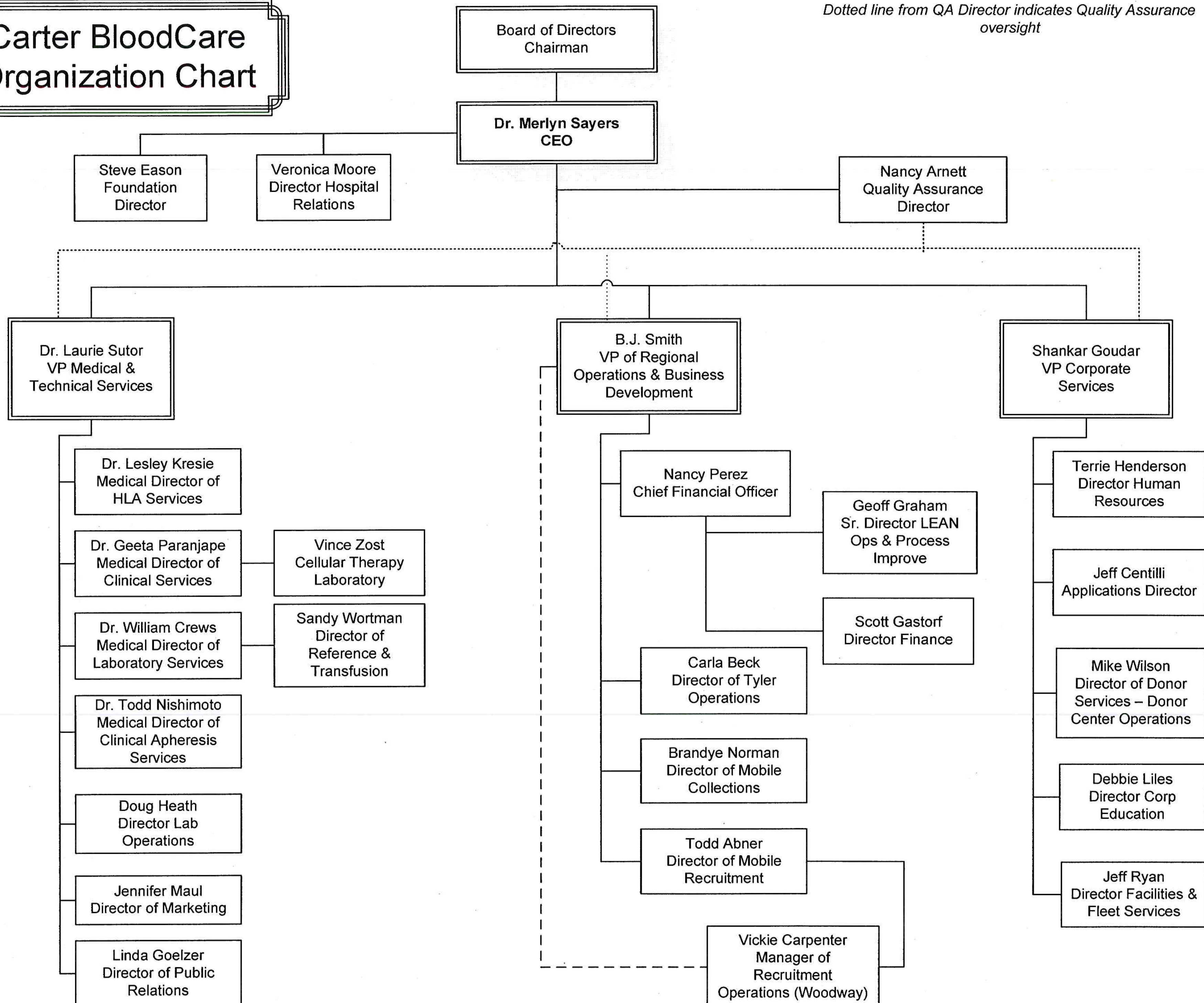
.4 Routine
.5 Hospital to Hospital Transfer
11.4 Delivery Response Times
11.5 Filling an Order
11.6 Delivery Options
11.7 Product Substitution
11.8 Emergency Release
11.9 Inventory Management
11.10 Order Documentation
11.11 Return Policy and Quarantine Requests
11.12 Forms
12. Reference and Transfusion Service
12.1 General Information for Patient/Reference Testing Services
2. Contract
.1 Requisitions
.2 Specimen Collection and Preparation
.3 Sample Shipping Requirements
.4 Unacceptable Specimens
.5 Available Tests
.6 Test Priority (Does Not Include Delivery Time)
.8 Test Cancellation
.9 Results, Reports, Requests for Quarantine, and Requests for Historical Patient Antibody Testing Information
.10 Emergency Release of Untested Components
.11 Notification of Pending Test Completion
12.2 Reference Testing Services – Red Blood Cells
.1 Serological Testing
.2 Red Blood Cell Antigen Screening
.3 Red Blood Cell Crossmatch Services
12.3 Reference Testing Services – Platelets
.1 HLA matching
.2 Platelet Antibody Screening and Crossmatching
.3 Requesting Platelet Testing Services
.4 Sample Requirements for Platelet Testing Services
.5 Platelet Labeling
12.4 Reference Testing Services – Molecular Testing Services
12.5 Reference Testing Services – Preventative Maintenance Services
12.6 Reference Testing Services – Cellular Therapy Services
12.7 Example Reports
12.8 Example Forms
13. Clinical Apheresis Services
13.1 Therapeutic Apheresis Services
13.2 Diseases which may be treated by Apheresis
13.3 Contract/Privileges
13.4 Emergency Privileges
13.5 Granulocyte Orders

13.6 Forms
14. Stem Cell Laboratory Services
14.1 Overview
14.2 Contract/Privileges
14.3 Emergency Privileges
14.4 Product Collection, Processing, and Infusion
.1 Collections of Peripheral Blood Stem Cells
.2 Institutional Responsibilities for PBSC Collection
.3 Donor Prescreen for PBSC and Marrow Collection
.4 Assisting with Surgical Harvest of Bone Marrow
.5 Processing and Cryopreservation
.6 Product Storage
.7 Thawing and Infusion
14.5 Forms
15. Medical Consultation Services
15.1 Suggested Services
16. Educational Opportunities
16.1 Carter BloodCare Tours
16.2 Hospital Forums
16.3 Staff In-services
16.4 External Audits Performed for Transfusion Services
16.5 Known Samples Provided
16.6 Reimbursement Review for Blood Product Coding
16.7 Transfusion Medicine Fellowship Rotation
16.8 Resident Pathologist Blood Center Rotation
16.9 Medical Student Blood Center Community visits
17. Memos and Updates


Carter BloodCare
Organization Chart
Board of Directors
Chairman
Dr. Merlyn Sayers
CEO
Dotted line from QA Director indicates Quality Assurance oversight
Steve Eason
Foundation
Director
Veronica Moore
Director Hospital
Relations
Nancy Arnett
Quality Assurance
Director
Dr. Laurie Sutor
VP Medical &
Technical Services
B.J. Smith
VP of Regional
Operations & Business
Development
Shankar Goudar
VP Corporate
Services
Dr. Lesley Kresie
Medical Director of
HLA Services
Dr. Geeta Paranjape
Medical Director of
Clinical Services
Vince Zost
Cellular Therapy
Laboratory
Dr. William Crews
Medical Director of
Laboratory Services
Sandy Wortman
Director of
Reference &
Transfusion
Dr. Todd Nishimoto
Medical Director of
Clinical Apheresis
Services
Doug Heath
Director Lab
Operations
Jennifer Maul
Director of Marketing
Linda Goelzer
Director of Public
Relations
Nancy Perez
Chief Financial Officer
Geoff Graham
Sr. Director LEAN
Ops & Process
Improve
Scott Gastorf
Director Finance
Carla Beck
Director of Tyler
Operations
Brandye Norman
Director of Mobile
Collections
Todd Abner
Director of Mobile
Recruitment
Vickie Carpenter
Manager of
Recruitment
Operations (Woodway)
Terrie Henderson
Director Human
Resources
Jeff Centilli
Applications Director
Mike Wilson
Director of Donor
Services – Donor
Center Operations
Debbie Liles
Director Corp
Education
Jeff Ryan
Director Facilities &
Fleet Services
Effective June 14, 2018

AUTOLOGOUS WORKSHEET

Patient Name:	Hospital Name:
Social Security Number:	Surgery Date:
Medical Record Number:	Physician Name:
Date of Birth: Sex:	Physician Phone Number:
Procedure:	Physician Fax Number:

Components Ordered: ________ RBC ________ PEDI ________ CRYO ________FFP

Donation Identification Number	Collection Date	Prepaid		Label Review Acceptable? Initial/Employee #	
		Yes	No	Yes	No

Comments\Special Instructions:

Copyright © 2018

AUTOLOGOUS WORKSHEET

Patient Name:	Hospital Name:
Social Security Number:	Surgery Date:
Medical Record Number:	Physician Name:
Date of Birth: Sex:	Physician Phone Number:
Procedure:	Physician Fax Number:

Components Ordered: ________ RBC ________ PEDI ________ CRYO ________FFP

Donation Identification Number	Collection Date	Prepaid		Label Review Acceptable? Initial/Employee #	
		Yes	No	Yes	No

Comments\Special Instructions:

Copyright © 2018

TO: ____
Physician Name / Hospital Name

FROM: **Carter BloodCare**
Special Donations Department and Carter BloodCare Physicians ____________________
Date

RE: **Autologous/Directed Donation Attempt for** ______________________________________.
Donor Name

According to our records, _________ unit(s) of blood were to be donated before the procedure. Thus far,

__________ unit(s) have been collected. An attempt was made to draw blood for a

scheduled ______________________________________ on ___________________
Procedure Date

at ____.
Hospital

Unfortunately, blood from that donation attempt will not be available for the procedure.

Listed below is/are the reason(s) the unit(s) will not be available:

____ Donor did not meet our eligibility requirements

____ Quantity of blood collected was not sufficient for transfusion

____ Other: ____

Comments:

____

____

____

____

NOTE: Donor ____IS ____IS NOT eligible to donate again prior to the procedure. If you have any questions, please contact Special Donations at 1-866-525-3378 or 817-412-5308. We apologize for any inconvenience this may cause.

This form contains health information that is privileged and confidential, the disclosure of which is governed by federal and state laws. If you are not authorized to use or disclose this information, you are hereby notified that any use, dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this form by error, please notify Carter BloodCare at (817) 412-5308 immediately.

Copyright © 2018

INSTRUCTIONS

1. Document physician name or hospital name.
2. Document current date.
3. Document donor name.
4. Document quantity of unit(s) to be donated before the procedure.
5. Document quantity of unit(s) that has already been collected from the donor.
6. Document type of procedure, if applicable.
7. Document date the procedure is scheduled.
8. Document hospital where the procedure will be performed.
9. Document the reason the unit will not be available (if "Other," list reason).
10. Document any additional comments.
11. Document whether donor is or is not eligible to donate again prior to the procedure.

Copyright © 2018

Carter BloodCare

DIRECTED WORKSHEET

Patient Name:	Hospital Name:
Social Security Number:	Surgery Date:
Medical Record Number:	Physician Name:
Date of Birth: Sex:	Physician Phone Number:
Procedure:	Physician Fax Number:

Components Ordered: ________ RBC ________ WHOLE BLOOD ________ RBC/CRYO ________ RBC/FFP
________ PEDI ________ 2- Unit RBC ________ Other

Donation Identification Number	Collection Date	**Blood Relative Yes**	**Blood Relative No**	Prepaid		Acceptable Label Review (Initials/Employee #)	
				Yes	No	Yes	No

☐ Irradiation performed by hospital blood bank, if applicable. ☐ Irradiation performed by CBC, if applicable.

☐ Restricted Donation – Don't cross into inventory

Comments/Special Instructions:

Copyright © 2018
For Training Only

Carter BloodCare

DIRECTED WORKSHEET

Patient Name:	Hospital Name:
Social Security Number:	Surgery Date:
Medical Record Number:	Physician Name:
Date of Birth: Sex:	Physician Phone Number:
Procedure:	Physician Fax Number:

Components Ordered: ________ RBC ________ WHOLE BLOOD ________ RBC/CRYO ________ RBC/FFP
________ PEDI ________ 2- Unit RBC ________ Other

Donation Identification Number	Collection Date	**Blood Relative Yes**	**Blood Relative No**	Prepaid		Acceptable Label Review (Initials/Employee #)	
				Yes	No	Yes	No

☐ Irradiation performed by hospital blood bank, if applicable. ☐ Irradiation performed by CBC, if applicable.

☐ Restricted Donation – Don't cross into inventory

Comments/Special Instructions:

Carter BloodCare
Copyright © 2018
SDF801.02B
Version: 11
Effective Date: 07/31/2018

- Please refer to Section 10.0, Test Information Chart, for specific sample requirements for platelet antibody screens, compatible platelet crossmatch and HLA testing.

NOTE: Serum separator tubes are not acceptable.

12.3.5 Platelet Labeling

HLA matched platelets are indicated as such on a yellow tie tag attached to the component. Information on the tag includes:

- Patient name
- Patient Identification number
- Hospital/Facility
- Unit Number
- Grade/interpretation of HLA match

Crossmatched platelet components are indicated as such by a manila tie tag attached to the component. Information on the tag includes:

- Patient name
- Patient Identification number
- Hospital/Facility
- "Platelet Crossmatched" circled on one side and stamped on the reverse side

12.4 MOLECULAR TESTING SERVICES (AABB ACCREDITED)

- Donor and Patient RBC genotyping/ Predicted phenotype testing (Common and Rare Antigen Systems)
- Discrepancy Resolution and 24/7 Consultation Services
- Handling of Specialized testing (i.e. RHCE and DNA sequencing)

12.5 PREVENTATIVE MAINTENANCE SERVICES

- Pipette Calibration and Maintenance
- Digital Timer Calibration
- Thermometer Standardization
  NOTE: Forms available on iWeBB®

12.6 CELLULAR THERAPY SERVICES

- Cell Surface Markers: CD34, CD3, TCR
- Clinical Apheresis: NMDP Donors
- Hematology: Donor Pre CBC, Product CBC, WBC

12.7 Example Reports:

- RTF102.03 Immunohematology Final Report
- RTF102.04 Preliminary Report
- RTF104.15 Reference and Transfusion Specimen Rejection Report

12.8 Example Forms:

- APL100 Apheresis Product Tag
- APL100 Crossmatched Apheresis Product Tag
- RAF601.00 Request for Product Quarantine, Records Audit and Data Entry
- RTF101.01A Reference and Transfusion Services Request Form(2 part carbonless)
- RTF103.01A Reference and Transfusion Service Patient Historical Record-Bedford
- RTF120.11A Request for Product Quarantine, Discard, or Retrieval
- RTF120.11D Reference and Transfusion Suspected Component Contamination Notification
- RTF214.01 Uncrossmatched Product Release
- RTF214.03 Untested Product Release form
- RTL214.01 Emergency Release Uncrossmatched Blood Label
- RTL214.03A Previous Donation Results Label
- RTL214.03B Testing Not Performed Label
- RTL422.01 HLA Matched Tie Tag
- Non-Crossmatch Compatibility Tag
- Crossmatch Compatibility Tag
- RTL207.01A Confirmed Antigen Typing
- RTL207.01C Molecular Matched Antigen Typing
- RTF101.01F Flow Cytometry Cellular Therapy Request

Carter BloodCare

FLOW CYTOMETRY CELLULAR THERAPY REQUEST

Received By R&T (Date/Time) ____________________

Patient Name: ______________________ Patient ID Number: ______________________

Patient DOB: ______________________ Sex: ☐ Male ☐ Female

Donor Name/ID (if applicable): ______________________

Requesting Facility: ______________________ Requesting Physician: ______________________

EDTA Tube: 500 µL to 1 mL (minimum)

Sample Collected By: ______________________

Date: ______________________

Time: ______________________

Place Patient Label Here, if available

FLOW CYTOMETRY CELL SURFACE MARKER TESTING

☐ **CD34** ☐ **CD3** ☐ **TCR** (α/β, CD19) ☐ Other: ______________

Peripheral Blood ☐ Patient Monitor ☐ Patient/Donor Pre-Collection

Apheresis Product ☐ Autologous ☐ Allogeneic

Bone Marrow Product ☐ Autologous ☐ Allogeneic

Special Processing ☐ Pre Processing ☐ Post Processing ☐ Other ______________

Unit Number/DIN: ______________________ **Collection Number:** ______________________

Product/Peripheral Blood WBC Count: ______________ x 10^3 / µL **Product Volume:** ______________ mLs

CBC CLINICAL APHERESIS USE ONLY

NMDP Donors:

Donor Identifier: ______________________ **Recipient Identifier:** ______________________

Requested By: ______________________ **Requester's ID#:** ______________________

Specimen Collected By: ______________________ **Date/Time:** ______________________

Call Results to (Name/Number): ______________________

Fax Results to (Check Applicable):

☐ Clinical Apheresis Office (972-661-9409) ☐ Preston Valley Donor Center (972-980-9167)

☐ Rosedale Donor Center (817-810-9443) ☐ Other: ______________________

Sent to R&T Date/Time: ______________________ For any questions, call Flow Cytometry (817-412-5744)

HEMATOLOGY TESTING REQUESTED (Check Applicable)

☐ **Donor** Pre CBC with Automated Differential

☐ **Product** CBC with Automated Differential

☐ **Other:** ______________________

HEMATOLOGY SERVICES USE ONLY

WBC Results: ______________ x 10^3 / µL

Called Results to: ______________________

Faxed Results to: ______________________

Tech/Date/Time: ______________________

REFERENCE & TRANSFUSION SERVICES USE ONLY

Results to: ______________________ **Date/Time:** ______________ **Tech:** ______________

☐ **Faxed** ☐ **Called** ☐ **Delivered** ☐ **Other:** ______________________ **Tech:** ______________

Copyright © 2018