EXCEPTIONAL REQUEST AND DISTRIBUTION OF PRODUCTS WITH INCOMPLETE ANALYSES

FAX TO HOSPITAL CUSTOMER SERVICE (514) 904-2522 / 1 (866) 811-9465

SECTION 1 – TO BE COMPLETED BY THE REQUESTING PHYSICIAN

Customer : ____________________

Traceline request number : ____________________

Patient's name: ____________________

Gender ☐ F ☐ M DOB (dd-mm-yyyy) : ____________________

Name of requesting physician: ____________________

Product requested: ____________________

Quantity requested: ____________________

Group ______ Rh ____ anti-CMV neg ☐ Yes ☐ N/A

Irradiated by Héma-Québec ☐ Yes ☐ No

Important: HQ will select a donor according to ABO Rh group and anti-CMV determination, as known in its computer system and based on the results of a previous donation.

Clinical reason: ____________________

I agree to receive products for which the analyses are incomplete.

Signature of requesting physician: ____________________ Date (dd/mm/yyyy) : ____________________

SECTION 2 – AUTHORIZATION BY HÉMA-QUÉBEC (TO BE OBTAINED BEFORE DISTRIBUTION)

VERBAL AUTHORIZATION (IF REQUIRED):	WRITTEN AUTHORIZATION :
NAME OF HQ DOCTOR ON DUTY : ____________	SIGNATURE OF HQ DOCTOR ON DUTY : ____________ DATE : ____________
CALL MADE BY : ____________ DATE : ____________	

SECTION 3 – PRODUCTS TO BE RELEASED (SCH): COMPLETE THE TABLE ACCORDING TO THE INFORMATION CONTAINED ON ENR-00791

DONATION NUMBER OR PLATELET POOL NUMBER	DATE OF COLLECTION OR PREPARATION (dd-mm-yyyy) :	POOL DONATION NUMBERS (IF A POOL IS TO BE RELEASED)

Completed by (initials) : __________ Date : ____________

SECTION 4 – ANALYSES (SCH,ÉTI)

RESULTS OF THE PREVIOUS DONATION ARE INCLUDED WITH THE SHIPMENT.	PREVIOUS DONATION NUMBER(S) :		
	____________	____________	____________
	____________	____________	____________

To the attending physician, we hereby confirm that for the donations mentioned above, the analyses usually performed by Héma-Québec <u>have not all been completed</u>.

PLATELET PRODUCTS ONLY ☐ N/A	**Bacterial culture:** ☐ Sample collected * ☐ Culture not tested ☐ Pending (Follow-up only if positive culture) * Sample taken before the 48-hour waiting period specified in the sampling protocol
Approximate date and time of the availability of results: ____________ ________	

Analyses	Pending
ABO et Rh	☐
Irregular Ab research (AB DEP MP)	☐
Syphilis (SYPH -D-END)	☐
HIV (HIVDUO)	☐
Anti-HTLV-I/II (HTLV -D-END)	☐

Analyses	Pending
Anti-VHC (HCV -D-END)	☐
HBsAg (VHB -D-END)	☐
Anti-HBc (HBC -D-END)	☐
TAN HIV-HCV-HBV (TANMUL-DEP)	☐

Analyses	Pending	Not Tested
Chagas screening	☐	☐
TAN WNV (TANWNV -DEP)	☐	☐
Anti-CMV	☐	☐
TAN-B19	☐	☐
TAN-HAV	☐	☐

ePROGESA order number : ____________

Completed by (SCH): Initials : ____ Date : ____________ | Verification of pending analyses (ÉTI): Initials : _____ Date : ____________

SECTION 5– IRRADIATION AND RELEASE (ONLY FOR GRANULOCYTES)

EXP	<u>Irradiation completed (EXP)</u> : ☐ Yes* ☐ N/A Initials : _______ Date : ____________ ** : To rule according to all the criteria described in PFN-00163.* <u>Transmission of complete documentation to QA (ENR-00533, Previous donations, Irradiation report, ENR-00791, ENR-02189):</u> Completed by : Initials : _______ Date : ____________
QA Release	Documented by : Initials : _________ Date : ____________

SECTION 6 DISTRIBUTION (EXP)

FORWARD TO CUSTOMER AS SOON AS AVAILABLE	Distribution Voucher No. : ____________
	Date and time of issue/packing : ____________ ______
	Completed by : Initials : ____________ Date : ____________