HOSPITAL TO HOSPITAL TRANSFER FORM

DOCUMENT ID CHF107 VERSION 1.0 EFFECTIVE DATE 3-1-18

Transfer Details

Shipper (facility transferred from)

Receiver (facility receiving transfer)

Transfer Date _______________ Time _______________

Products Shipped

Unit Number	Component	ABO/Rh Type	Expiration Date	Transportation (Specify company or individual)
				Courier
				Cab
				Other (specify)

Transfer Acknowledgement: By signing this document, the hospital receiving the transferred products agrees to pay Marsh Regional Blood Bank for the products listed above. The transferring hospital will be reimbursed for these units.

Transferring Hospital Representative

I have inspected each of the units listed above and determined that each one is suitable for shipment. All products in this shipment have been maintained at the appropriate temperature prior to shipment.

Name___________________________________ Title____________________

Signature _________________________________ Date _____________________

Shipper: 1. Send 1st and 2nd copies to the receiving hospital with the shipment.
2. Retain the third copy for your files.

Receiving Hospital Representative

I have inspected the shipment and determined that the temperature on receipt of the shipment is acceptable.

Name_________________________________ Title __________________

Signature: _____________________Date: ________ Temperature on receipt: _______

Receiver: 1. Complete receiving hospital information on form.
2. Return the top copy to Marsh to the attention of Robin Cross by courier or mail.
3. Retain the 2nd copy for your files.