CUSTOMER CONNECTION
Mississippi Valley Regional Blood Center

Customer: _____ Date:_____

Name of person initiating the form:_____

Was someone contacted prior to completion of form?
YES (Phone □ Fax □ E-mail □ Mail □ OOS □) NO □

If yes, name of person contacted (include name and location of person contacted):
_____

	Unit Number	Product Code
Irradiation Credit		
Product/Segment Hemolyzed		
Product Broken		
Upon Receipt		
Upon Thawing		
Other (please explain below)		
Other events		
Delay in Shipment		

Was patient care delayed because of this? Yes □ No □
Please rate severity of the situation by marking the box of chosen rating. (1 is low; 5 is high)

	1	No Impact
	2	Product/Service did not meet expectations: No affect to safety, purity, potency or quality of patient outcome.
	3	Product/Service did not meet expectations: high potential to affect safety, purity, potency, or quality of patient outcome.
	4	Product/Service did not meet expectations: did affect safety, purity, potency, or quality of patient outcome.
	5	Product/Service did not meet expectations: did affect safety, purity, potency, and caused serious harm, injury, or death.

Comments:
_____
_____
_____