

 DIAGNOSTIC SERVICES OF MANITOBA SERVICES DE DIAGNOSTIC DU MANITOBA	DSM Customer Feedback Form		Document # F160-INV-23
			Version # 01
	Approved by: 	Effective Date: 31-MAR-2011	Source Document: Manitoba Transfusion Quality Manual for Blood Banks

Contact Information (Receiving Site)	DSM TM Office Use Only
Name:	Date Received:
Position:	Received By:
Facility:	

Please provide as much information as possible, including unit/lot numbers and supporting documents

Date Received:	Date Occurred (if different):	
DSM Facility Involved in Occurrence:		
Discussed with _____ at _____ on _____ (if applicable)		
Blood, Blood Component or Derivatives Type: <input type="checkbox"/> RBC <input type="checkbox"/> Platelets <input type="checkbox"/> FFP <input type="checkbox"/> Cryosupernatant Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Derivatives <input type="checkbox"/> Other: _____		
Product Quality	Product Delivery	Service Delivery
Type: <input type="checkbox"/> Hemolyzed <input type="checkbox"/> Lipemic/Icteric <input type="checkbox"/> Damaged/Broken Pack <input type="checkbox"/> < 4 Segments <input type="checkbox"/> DAT Positive <input type="checkbox"/> Illegible Date <input type="checkbox"/> Incomplete Order Received <input type="checkbox"/> Incorrect Order Received	<input type="checkbox"/> Packing Slip Incorrect <input type="checkbox"/> Product Tag Incorrect <input type="checkbox"/> Patient Report Incorrect <input type="checkbox"/> Incorrect Packaging <input type="checkbox"/> No Security Seal <input type="checkbox"/> Temperature upon Receipt _____	<input type="checkbox"/> Communication Problem <input type="checkbox"/> Delivery Delay
Description:		

Date Faxed: _____ **(DSM TM Office (204) 235-3768)**
Date Faxed: _____ (Shipping Site)