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. (1 is low; 5 is high) 1 2 3 4 5

Please explain details:
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