Atlanta Blood Services Atlanta, GA 30342 Returned/Transferred Blood Component Invoice

Both facilities please complete pertinent information and fax to (404)459-8738 or email to ccox@bmtga.com

Date :__

Please send the completed form as soon as possible and prior to the end of the month when the transfer/return occurred. Please send all requests before the 3 rd business day of the following month to receive credit.									
To be completed by the Consignee							uit.	To be Completed by Receiving Facility	
Unit Numbe	·r	Product Code	ABO Type	Expiration Date	Reason fo Return. N/A for transfers	Name of Hospital/F product is transporte	•	Condition at receipt A/UA*	Tech initials and Date
Records are Signature of	available at m Person Packi	eing transferred/returned have been maintained in a controlled manner. y facility that verify that the information selected on this form is correct. ng the Products:							
Select one of the options below and Sign where designated.									
		For Product physically returned or transferred , I certify that the products listed above have been stored in appropriate manner to maintain proper storage conditions including proper temperature range (listed below). I have packaged these products to ensure the products will remain at the transport temperature listed below.							
		The products listed above are not being physically returned. I certify that they were discarded at our facility.							
		The products have been Shipped to the Hospital listed above							
	able UA Unad N=No N/A= N		le						
ABS Use Only									
Receipt T by ABS		ech		Date/Time		Temperature (if applicable)		Product Returned/Transferred in BBCS	

Red Blood Cells 1-6°C

Red Blood Cells 1-10°C

Plasma ≤180C

Plasma: Remain Frozen

Form: CL.314B.2 Effective Date: 08/01/2022

Acceptable Storage Conditions: Platelets 20-24°C (agitated)

Acceptable Transport Conditions: Platelets 20-24°C

Initiating Transfusion Service:_