EXCEPTIONAL RELEASE OF NON-CONFORMING PLATELET COMPONENT

REASON FOR ISSUE: DCR39759: Amend reference in section 5 to the correct section of the form. Update for ISBT 128 longer donation number.

Donation / Pool Number: **Z0001**	**Component:**

SECTION ONE: TO BE COMPLETED BY LOCAL NZBS TMS / MO

Name of Treating Clinician:	
Contact No.:	**Hospital:**
Patient Name:	
NHI:	**Date Required:**
Clinical Justification:	

I have advised the treating clinician whose name is recorded above, of the risks associated with the use of the non-conforming product. I have also advised and discussed with the treating clinician the known alternative treatment options available for his/her patient.

I have confirmed that the treating clinician understands that non-conforming products are supplied by NZBS in urgent clinical situations only and confirmed that such a situation exists for the patient.

I have confirmed the treating clinicians' consent to use the NCP for his/her patient and that the requirement to gain consent for its use from the patient or next of kin is a clinical responsibility.

I have authorised the exceptional release of the non-conforming product. **YES / NO***

Name: _____

Signed: _____ Date: _____

**Record Reason if not authorised*:

SECTION TWO: TO BE COMPLETED BY REQUESTING COMPONENT PROCESSING DEPARTMENT

This section is intended to record the initiation of and justification for the request.

Department:	**Date:**
Name:	**Signature:**
Reason for request:	

SECTION THREE: TO BE COMPLETED BY LOCAL QUALITY BUSINESS PARTNER

If the request is after hours or during statutory holidays the QBP will review and sign the form at the earliest opportunity during office hours

I have authorised the exceptional release of the non-conforming product. **YES / NO***

Name: _____

Signed: _____ Date: _____

**Record reason if not authorised:*

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SECTION FOUR: TO BE COMPLETED BY COMPONENT PROCESSING

If the request is after hours or during statutory holidays technical staff may release the product after authorisation from the TMS / MO and prior to the QBP having reviewed and signed.

Component Released:	**Date:**	**Initial:**
Expiry Date Amended to:		**Depot Moved to:** *(hospital)*
Completed Results:	**Date:**	**Initial:**
• Attach a copy of the completed results. • Forward to TMS / MO upon completion of all results. • If results are reactive / positive forward to TMS / MO without delay		Record QPulse incident No:
Completed 111L002 attached to non-conforming platelet ☐ *tick* Exceptional release recorded on 150F089 Release of Non-Conforming Products Register ☐ *tick*		

SECTION FIVE: TO BE COMPLETED BY BLOOD BANK

Transfusion of Component:	
Patient Name :	
NHI:	**Date Transfused:**
• Scan the completed form back to the originating Component Processing department • If the component is not transfused to the patient recorded in Section One, return the non-conforming component to the originating Component Processing department.	

SECTION SIX: REVIEW BY NATIONAL MANAGER

Date:	
Name:	**Signature:**
Comments:	