

NAME & ADDRESS OF BLOOD BANK

Licence No.:- _____

CLINICIAN'S FEEDBACK FORM

(GD-4)



Your details:

Name: _____ Unit/Speciality: _____

Qualification: _____ Designation: _____

Institution: SKH Any other (if Yes, than specify _____

Contact number: _____

Please use the space given below to tell us how we are doing.

Sr. No.	Please tick according to the services you received	SCORE					
		Excellent		Good		Unsatisfactory	
RESPONSE OF BLOOD BANK STAFF							
1.	a) Courteous and helpful behavior						
	b) Promptness						
AVAILABILITY OF BLOOD/COMPONENTS							
2.	a) When available						
	b) Made available when out of stock						
TURN AROUND TIME		Routine	Urgent	Routine	Urgent	Routine	Urgent
3.	a) Whole Blood						
	b) Red Blood Corpuscles						
	c) Platelets						
	d) Cryoprecipitate AHF						
	e) Fresh Frozen Plasma						
	f) Plasma Cryoprecipitate Reduced (CPP)						
4.	RESPONSE IN CASE OF SUSPECTED BTR(Blood Transfusion Reaction)						
5.	ADVISORY SERVICES OFFERED						
6.	OVERALL SATISFACTION						

Suggestions for improvement:

Date:

Signature:

**THANK YOU FOR YOUR FEEDBACK AND FOR HELPING US.
 [FOR USE IN BLOOD BANK ONLY]**

Reviewed by: Head BB, / QM BB

Signature _____

Action taken / Proposed action by the Blood Bank:
