**CUSTOMER SERVICES REPORT**

<table>
<thead>
<tr>
<th>Complaint Initiated by: (Check all that apply and list names)</th>
<th>Occurrence Date/Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Donor:</td>
<td></td>
</tr>
<tr>
<td>□ Blood Drive Location:</td>
<td></td>
</tr>
<tr>
<td>□ Physician:</td>
<td></td>
</tr>
<tr>
<td>□ Hospital:</td>
<td></td>
</tr>
<tr>
<td>□ LIFELINE:</td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reported By/Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone number:</td>
</tr>
</tbody>
</table>

Fax number (if applicable):

Employee(s) involved:

**Check all that apply:**

**Community Services:**
- □ Donor Recruitment
- □ Tele-Recruitment
- □ Blood Drive Follow-up
- □ General Customer Service
- □ Other

**Donor Services:**
- □ Fixed Site
- □ Mobile # ___
- □ Registration
- □ Physical
- □ Medical History
- □ Phlebotomy
- □ Post Donation (injury, reaction, incident)
- □ General Customer Service
- □ Other

**Quality and Regulatory Services:**
- □ General Customer Service
- □ Other

**Admin/Information Services**
- □ General Customer Service
- □ Other

**Technical Services:**

**Laboratory**
- □ Antibody ID
- □ Compatibility
- □ Special Orders
- □ General Customer Service
- □ Other

**Components**
- □ Label/Typing
- □ Autologous/Directed
- □ General Customer Service
- □ Other

**Distribution**
- □ Order
- □ Delivery
- □ Condition Unacceptable upon Receipt
- □ General Customer Service
- □ Other

**Product**
- □ TTD
- □ TRALI
- □ Bacterial Contamination
- □ Other

**Brief Explanation:**

<table>
<thead>
<tr>
<th>Was Donor/Patient adversely affected by incident?</th>
<th>□ Yes □ No □ N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor/ Patient Physician notified:</td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>Physician Name:</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

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- R:\Regulatory Services\183 Sterling Farms Drive\Forms\Miscellaneous Forms\FORM#QRS-J3a - Customer Service Report.doc
## CUSTOMER SERVICES REPORT INVESTIGATION
### LIFELINE BLOOD SERVICES

<table>
<thead>
<tr>
<th>Root Cause:</th>
<th>Action Taken:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Training/Proficiency</td>
<td>☐ Retraining</td>
</tr>
<tr>
<td>☐ SOP’s</td>
<td>☐ Review with Staff</td>
</tr>
<tr>
<td>☐ Supervision/Management</td>
<td>☐ SOP revision/new SOP developed</td>
</tr>
<tr>
<td>☐ Equipment</td>
<td>☐ CPA process initiated</td>
</tr>
<tr>
<td>☐ Accident</td>
<td>☐ Help Me Report initiated</td>
</tr>
<tr>
<td>☐ Error</td>
<td>☐ Error Report initiated</td>
</tr>
<tr>
<td>☐ Not Applicable</td>
<td>☐ Not Applicable</td>
</tr>
<tr>
<td>☐ Other (please describe)</td>
<td>☐ Other (please describe)</td>
</tr>
<tr>
<td></td>
<td>☐ HR form initiated</td>
</tr>
</tbody>
</table>

**Comments:**

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**External Review:**
**(if applicable)**

Date:

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**FAX COMPLETED FORM TO: 731-424-1574 OR MAIL TO:**
LIFELINE Blood Services
ATTN: Quality and Regulatory Services
183 Sterling Farms Drive
Jackson, TN 38305

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**LIFELINE Employee(s) Signature:**
**(if applicable)**

Date:

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**LIFELINE Department Director Review:**

Date:

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**Comments:**

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**FORWARD COMPLETED FORM TO QUALITY AND REGULATORY SERVICES**

**LIFELINE QRS Review:**

Date:

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**Comments:**

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CSR referred to Corrective/Preventative Action-Change Control Process:  Yes _____  No _____

Reviewed by: ____________________________  Date: ____________________________

Returned to Customer by: ____________________________  Date: ____________________________