Vitalant Coagulation Lab
Quality Control Submission Form

Vitalant Coagulation Laboratory
875 Greentree Rd, 5 Parkway Center – Suite 122, Pittsburgh, PA 15220
800-967-9672 Email: DL-SLT_COSS@vitalant.org

Facility Contact

Facility Name: ____________________ Contact Person Name: ____________________
Mailing Address: ____________________ Phone: ____________ Fax: ____________
City: ____________ State: ________ Zip: ________ Email: ____________________

Test Requests

Reason: ☐ 1 – Quality Control ☐ 2 – Validation ☐ 3 – Corrective Action/Investigation ☐ 4 – Other (Specify): ____________

Sample Type:

- ☐ Cryo Pool
  # of Units in Pool: ______
- ☐ Individual Cryo
  # of Singles Sent: ______
- ☐ Source Plasma
  Check all required:
  ☐ FVIII ☐ Total Protein
- ☐ Recovered Plasma
  Check all required:
  ☐ FVIII ☐ Fibrinogen ☐ Total Protein
- ☐ Other: ____________
  Check all required:
  ☐ FVIII ☐ Fibrinogen ☐ Total Protein

Product Information

Please Circle	Product 1 (single or pool)	Product 2 (single or pool)	Product 3 (single or pool)	Product 4 (single or pool)	Product 5 (single or pool)
DIN (Place barcode)					
ABO/Rh					
Volume					
Exp. Date					
Prep. Date					

COAG Lab Use Only

Product Information

Please Circle	Product 6 (single or pool)	Product 7 (single or pool)	Product 8 (single or pool)	Product 9 (single or pool)	Product 10 (single or pool)
DIN (Place barcode)					
ABO/Rh					
Volume					
Exp. Date					
Prep. Date					

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