ST. CHRISTOPHER’S HOSPITAL FOR CHILDREN
HEMACHRON LIQUID QC LOG

Location:___________ Response S/N:_____________________
Date:_______________Reviewer Signature___________________________
Date:_______________Reviewer Signature___________________________

Liquid Controls Q Week								
	Normal			**Abnormal**			**Well # and Tube Lot #**	**Initals**
Date	Lot No./ Exp date	Range	Result	Lot No./ Exp. Date	Range	Result		

Date	**Initials**	**POCT Tester’s Signature/Title**	**Date**	**Initals**	**POCT Tester’s Signature/Title**