Problem Reporting Form

Hospital:	
Unit # (if applicable):	**Component or Supplies:** (e.g., RBC, PLC, blood bag, filter)
Date Received:	**Blood Center Notified:**_____Yes ____No

Error(s) and/or problem(s) that occurred: *(More than one may be marked if applicable)*

☐ ABO/Rh:
Mistyped as: _____
Retyped as: _____

☐ Transfusion date (Autologous/Directed donation)
Incorrect date: _____
Correct date: _____

☐ Incorrect Identifying Information
(Autologous/Directed donations e.g., name, Social security no., birth date)
Incorrect date: _____
Correct date: _____

☐ Incorrect problem label
Incorrect product: _____
Correct product: _____

☐ Expiration date
Incorrect date: _____
Correct date: _____

☐ License not crossed off

☐ Volume not on label

☐ Biohazard label not on unit

☐ Supplies lot#_____

☐ Product Return *(check all that apply)*
___ Broken Bag
___ Bag leaking
___ Clotted
___ Hemolyzed
___ Improper shipping temp
___ Positive DAT
___ Unusual appearance
(specify) _____
___ Improper storage at hospital

☐ Other_____

Comments/Corrective Actions/Additional documentation: *(Describe errors or problems and corrections made or action taken. Also note if any of the unit was transfused. Use back or attachments if more space is needed.)*

Hospital employee filling out this report: _____

Date Units or Supplies returned to LifeServe: _____

Please fax to the appropriate Distribution Center:

Johnston	515-288-4683	Sioux City	712-252-1013
Mason City	641-424-4190	Cedar Falls	319-433-0464
Omaha	515-309-4969	Davenport	319-433-0464