

**New Jersey Department of Health
Clinical Laboratory Improvement Service
PO Box 361
Trenton, NJ 08625-0361
TRANSFUSION REACTION REPORT**

INSTRUCTIONS:

1. Pursuant to N.J.A.C. 8:8-5.2, blood banks must report hemolytic and/or delayed hemolytic and other known or suspected life-threatening transfusion reactions within 10 days of the occurrence using this form; and must report known and/or suspected fatal transfusion reactions by telephone call to 609-406-6829 by the next working day after the day the event occurs, with written follow-up within 10 days of the occurrence, using this form.
2. Forward the original copy of the report to the address listed above; retain a copy for your records.
3. If there are any questions, contact the Blood Bank Unit at 609-406-6829.
4. Briefly summarize the events leading to the reaction below. Attach copies of the transfusion reaction work-up performed.
5. Describe corrective action(s) taken to prevent adverse event from recurring.

Name of Blood Bank		Telephone Number
Date of Transfusion	Time of Transfusion	Day, Date and Time of Reaction
Amount of Blood Transfused	Patient ABO Group	Donor ABO Group
Location of Patient at Time of Reaction		
Patient Name	Patient Age	Diagnosis
Type of Reaction <input type="checkbox"/> Fatal <input type="checkbox"/> Non-Fatal <input type="checkbox"/> Hemolytic <input type="checkbox"/> Anaphylactic <input type="checkbox"/> Delayed Hemolytic <input type="checkbox"/> a. Amount of time after transfusion _____ <input type="checkbox"/> b. Specify antibody, if applicable _____ <input type="checkbox"/> Bacterial (List Organism) _____		
Describe Events Leading to the Reaction and Corrective Action Taken (If more space is needed attach additional sheets.)		
Date Reported	Name of Blood Bank Director	Signature of Blood Bank Director