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 609-718-8084 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 609-718-8084.*
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 error 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

- ☐ Fatal ☐ Non-Fatal
  - ☐ Hemolytic
  - ☐ Anaphylactic
  - ☐ Delayed Hemolytic
    - ☐ a. Amount of time after transfusion _____
    - ☐ b. Specify antibody, if applicable _____
  - ☐ 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

Forward completed Report to address listed above; retain a copy for your records.