

**New Jersey Department of Health
Clinical Laboratory Improvement Services
PO Box 361
Trenton, NJ 08625-0361**

BLOOD BANK ANNUAL STATISTICS (HOSPITALS)

Name of Blood Bank	County	Code Number
Address		
Name of Individual Completing Form	Telephone Number	

Please furnish the following data for the report year and return to the above address. Please retain a copy for your files.

To cross-check your numbers, please balance your figures according to the following formula before submitting your data:

$$\begin{array}{l}
 \textit{Total Supply} \\
 \textit{[units on hand + units received} \\
 \textit{+ units collected (if collecting)]}
 \end{array}
 =
 \begin{array}{l}
 \textit{Total Returned} \\
 \textit{+ Total Transfused} \\
 \textit{+ Total Discarded}
 \end{array}$$

If assistance is needed, contact the Clinical Laboratory Improvement Service at 609-406-6829.

A. SOURCES OF SUPPLY	Whole Blood	Red Cells*	Totals
1. No. of units successfully drawn in your bank:		//////////	
a. Routine (Allogeneic)			
b. Number of double red cell procedures performed by your bank in New Jersey (allogeneic) (_____ x 2 = _____.)	//////////		
c. Autologous		//////////	
d. Directed		//////////	
2. Number of units on hand January 1 of report year.			
3. Number of units (Total for Allogeneic, Autologous, Directed) supplied directly by:	//////////	//////////	//////////
a. Bergen Community Regional Blood Center			
b. Blood Center of New Jersey			
c. Central Jersey Blood Center			
d. Community Blood Council of New Jersey			
e. Miller Memorial Blood Center			
f. New Brunswick Affiliated Hospital Blood Program			

*Include frozen, washed and WBC-reduced red cells in this total (refer to Page 5, Section H, Number 5, 6 and 7).

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)
(CONTINUED)**

Name of Blood Bank		Telephone Number		
A. SOURCES OF SUPPLY, Continued		Whole Blood	Red Cells*	Totals
g. American Red Cross:				
1. Penn-Jersey, Philadelphia				
2. Other Red Cross				
h. New Jersey Blood Services/ New York Blood Center				
i. Out-of-State Community (Name and State)				
1.				
2.				
j. Commercial Blood Banks (Name and State)				
1.				
2.				
k. Blood Received Directly from AABB Exchange Programs (Actual units, not credits):				
1. Volunteer Sources				
2. Commercial Sources				
l. Directly from other hospitals				
TOTAL SUPPLY				
B. UNITS RETURNED (Only Unexpired Whole Blood or Red Cells for Allogeneic, Autologous and Directed Units)				Totals
1. Community Blood Banks				
2. American Red Cross				
3. New Jersey Blood Services/New York Blood Center				
4. Commercial Suppliers				
5. Sent to Other Hospitals:				
a. Through the American Assoc. of Blood Banks (actual units, not credits)				
b. By directed transfer				
6. Balance on hand December 31 of the report year				
TOTAL RETURNED				

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)
(CONTINUED)**

Name of Blood Bank					Telephone Number		
C. USAGE (Whole Blood and Red Cells)							
1. Number of crossmatches							
2. Number of patients transfused							
3. Number of units transfused (count split units as one)					Whole Blood	Red Cells	Totals
a. Transfused as Allogeneic							
b. Transfused as Autologous							
c. Transfused as Directed							
TOTAL TRANSFUSED							
D. DISCARDS	Allogeneic		Autologous		Directed		TOTALS
	Your Collec- tions	Other Sources	Your Collec- tions	Other Sources	Your Collec- tions	Other Sources	
1. Number of Units (Red Cells and Whole Blood) discarded from:		/////	/////	/////	/////	/////	/////
a. Outdating							
b. Reactive HBsAg							
c. Reactive HBcAb							
d. Reactive Test for HCV Antibody							
e. Reactive Test for HIV Antibody							
f. Reactive HTLV-1/HTLV-II							
g. Reactive Test for Syphilis							
h. Elevated ALT							
i. Irregular Antibodies							
j. Contamination, Breakage, etc.							
k. Donor Deferral Registry or Confidential Unit Exclusion							
l. Other-Specify (e.g., equipment failure):							
TOTAL DISCARDED							
2. Number of units in Question #1 above, confirmed positive for:					////////		
a. HIV							
b. HB _s Ag							
c. STS							
d. HCV							
TOTAL							

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)
(CONTINUED)**

Name of Blood Bank		Telephone Number	
E. NUMBER OF UNITS RECEIVED FROM SUPPLIERS (Do NOT include units collected at your facility)	Whole Blood	Red Cells	Total
1. Allogeneic			
2. Autologous			
3. Directed			
TOTAL			
F. NUMBER OF UNEXPIRED UNITS RETURNED TO SUPPLIERS:	<i>////////</i>	<i>////////</i>	<i>////////</i>
1. Allogeneic			
2. Autologous			
3. Directed			
TOTAL			
G. NUMBER OF TRANSFUSION REACTIONS:			<i>////////</i>
1. Febrile			
2. Allergic			
3. Hemolytic (Cause)			<i>////////</i>
a. ABO (Specify):			
b. Clerical (Specify):			
c. Technical (Specify):			
d. Non-Specific			
e. Other (Specify):			
4. Anaphylactic			
5. Delayed			
a. Antibody(ies) causing the reaction:			<i>////////</i>
b. Number of days after transfusion:			<i>////////</i>
6. TRALI			
7. Bacterial Contamination			
TOTAL			

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)
(CONTINUED)**

Name of Blood Bank						Telephone Number			
H. BLOOD COMPONENTS	Number of Units								No. of Patients Transfused
	Prepared in Your Bank	Received From			Total	Total Transfused by Your Bank	Total Out-dated	Total Ret'd to Source Blood Center	
		Name	State	No.					
1. Fresh frozen plasma									
2. Single donor platelets-SDP									
3. Platelet concentrate									
4. Cryoprecipitates									
5. Frozen red cells**									
6. Washed red cells**									
7. Leukoreduced red cells**									
a. by filtration									
b. by centrifugation									
c. prestorage leukoreduced									
8. Leukocytes									
9. Stem Cells									
10. Other (Specify):									
**Please include in packed cells under A (Page 1) and C3 (Page 3).									
I. APHERESIS (Collected in Your Facility)						Number of Donors	Number of Units		
1. Plasmapheresis									
2. Leukapheresis									
3. Plateletpheresis									
If performed by another licensed blood bank, write name below:									

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)
(CONTINUED)**

Name of Blood Bank		Telephone Number	
J. THERAPEUTIC APHERESIS (Collected in Your Facility)		Number of Patients	Number of Procedures
1. Plasma Exchange			
2. RBC Exchange			
3. Leukapheresis			
4. Plateletpheresis			
5. Stem Cell Harvesting			
If performed by another licensed blood bank, write name below:			
K. SALVAGED PLASMA			Total
1. Number of Units Salvaged:			<i>////////</i>
a. Total Units			
b. Total Liters			
L. DISTRIBUTION OF SALVAGED MATERIAL			
Nature of Material	Volume (In Liters)	Name and Address of Destination	
M. PERIOPERATIVE AUTOLOGOUS BLOOD COLLECTION AND ADMINISTRATION			Total
1. Number of intraoperative autologous procedures performed at your institution			
2. Number of postoperative autologous procedures performed at your institution			
3. Number of acute normovolemic hemodilution procedures performed at your institution			
4. Number of platelet rich plasma gel procedures performed at your institution			
TOTAL			
If performed by another licensed blood bank, write name below:			

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)
(CONTINUED)**

Name of Blood Bank		Telephone Number	
N. LEAST INCOMPATIBLE TRANSFUSIONS		Number of Patients	Number of Units
1. Total Number of Least Incompatible Transfusions			
O. HOSPITAL STATISTICS			Total
1. Total Number of Hospital Beds			
2. Total Number of Surgical Procedures			
P. PERSONNEL	Supervisor	Technologist	Technician
1. Total Number of Full Time Employees in Each Title			
2. Total Number of Part Time Employees (Prorated to full time: Total number of part time hours divided by 40 (round to nearest whole number).			
3. Total Number of Employees (1 + 2 = 3)			
Q. CORD BLOOD COLLECTIONS			Total Number of Collections
Name(s) of Licensed Cord Blood Banks that performs collections in your hospital			//////////
1.			
2.			
3.			
TOTAL			

Name of Blood Bank Director (Print)	Telephone Number
Signature of Blood Bank Director	Date