EQUIPMENT FAILURE/MALFUNCTION REPORT

PLEASE NOTIFY MEDIC BY PHONE IMMEDIATELY AND FAX
THIS COMPLETED REPORT FAX # (865) 521-2647

Equipment Failure/Malfunction
Reported: Date _____ Time_____ By _____

Hospital Transfusion Service _____

Equipment: Blood Bank _____ Recorder _____ Alarm _____

Type of Failure/Malfunction: _____

_____

Action Taken: _____

_____

UNIT NUMBERS OF RED BLOOD CELLS PLACED IN TEMPORARY STORAGE:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Placed in Temporary Storage By: _____ Date: _____ Time: _____

Initiate MEDIC form # TSI3.D.

Expected Time of Repair: _____

MEDIC Supervisor Review By: _____Date: _____

MEDIC Quality Review By: _____Date: _____