

## BLOOD CONTAINER PROBLEM REPORT

Date of Occurrence: \_\_\_\_\_ Number of Occurrences: \_\_\_\_\_ Reported by: \_\_\_\_\_

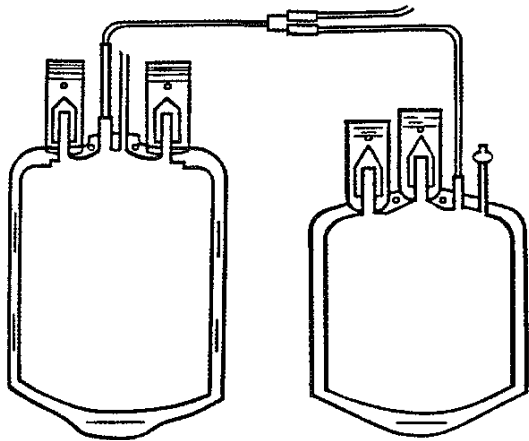
Product Name: \_\_\_\_\_

Unit Number: \_\_\_\_\_

Manufacturer's Product Number: \_\_\_\_\_ Lot Number: \_\_\_\_\_

TYPE OF BAG		TYPE OF DEFECT		DEFECT DETECTED	
Single	<input type="checkbox"/>	Hole (leak) in:		Before Phlebotomy	<input type="checkbox"/>
Double	<input type="checkbox"/>	Primary Bag	<input type="checkbox"/>	During Phlebotomy	<input type="checkbox"/>
Triple	<input type="checkbox"/>	Satellite Bag	<input type="checkbox"/>	During Stripping of Tubing	<input type="checkbox"/>
Platelet Pheresis	<input type="checkbox"/>	Hole in Tubing	<input type="checkbox"/>	Before Centrifugation	<input type="checkbox"/>
Plasma Pheresis	<input type="checkbox"/>	Crimp in Tubing	<input type="checkbox"/>	After Centrifugation	<input type="checkbox"/>
WB-Leuko-reduced RBC	<input type="checkbox"/>	Anticoagulant	<input type="checkbox"/>	Upon Thawing	<input type="checkbox"/>
RBC Pheresis	<input type="checkbox"/>	Needle	<input type="checkbox"/>	During Processing	<input type="checkbox"/>
Freezing Bag	<input type="checkbox"/>	Packaging	<input type="checkbox"/>	During Filtration	<input type="checkbox"/>
Other	<input type="checkbox"/>	Broken cannula	<input type="checkbox"/>	Other	<input type="checkbox"/>
		Other	<input type="checkbox"/>		<input type="checkbox"/>

(Circle Defect if collection container)



Comments: \_\_\_\_\_

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Response from Manufacturer and/or Action Taken: \_\_\_\_\_

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Quality Review: \_\_\_\_\_ Date: \_\_\_\_\_