

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: _____ Medic QA Review By: _____
Date: _____ Date: _____