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: ______________