CUSTOMER REPORT OF BLOOD CONTAINER PROBLEM

Date of Occurrence: ______________________________

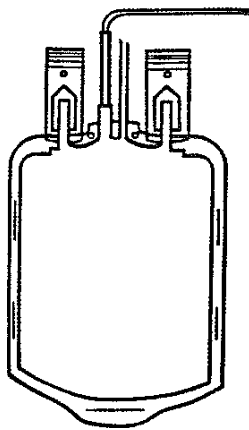
Product Name/Code: ______________________________

Donation Identification Number (DIN): ______________________________

Manufacturer's Product Number: ____________________ Lot Number: ____________________

TYPE OF PRODUCT		TYPE OF DEFECT		DEFECT DETECTED	
Platelet	☐	Hole (leak) in Bag	☐	Upon Thawing	☐
Plasma	☐	Hole in Tubing	☐	During Processing	☐
RBC	☐	Crimp in Tubing	☐	During Transfusion	☐
Freezing Bag	☐	Broken cannula	☐	Other	☐
Other	☐	Other	☐		

(Circle defect area on diagram)



Comments: ______________________________

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Reported by: ______________________________
(Hospital)

Name: ______________________________ Date: ____________________

Send completed form to MEDIC Regional Blood Center.

MEDIC Quality Review: ______________________________ Date: ____________________

MEDIC Regional Blood Center
1601 Ailor Avenue
Knoxville, TN 37921