

CHECK ONE BOX BEST DESCRIBING TYPE OF INCIDENT, AND COMPLETE REVERSE SIDE OF FORM

## I. BLOOD DONOR REACTIONS AND COMPLICATIONS

- A. Whole blood donors
- 1  ..... 1. Donor reaction requiring significant intervention
- B. Pheresis donors
1. Manual pheresis
- a. Wrong red cell infusion
- 2  ..... i. Compatible group
- 3  ..... ii. Incompatible group
- 4  ..... b. Other donor reaction requiring significant intervention
2. Automated pheresis
- 5  ..... a. donor reaction (resulting from equipment failure) requiring significant intervention
- 6  ..... b. donor reaction (NOT resulting from equipment failure) requiring significant intervention

## II. ERRONEOUS RELEASE OF BLOOD COMPONENTS

- 7  ..... A. Erroneous release to a transfusion service or patient of an untested or incompletely tested blood component
- 8  ..... B. Erroneous release to a transfusion service or patient of a homologous component with an unacceptable result on a required test (does not include release of pheresis products with abnormal results permitted by Subpart 58-2)
- 9  ..... C. Erroneous release to a transfusion service or patient of a homologous component determined to be unsuitable based on donor deferral records or significant donor history.
- 10  ..... D. Erroneous release to a transfusion service or patient of an unirradiated blood component.
- 11  ..... E. Release of a product later determined to be unsuitable.

## III. RECIPIENT TRANSFUSION ERRORS, REACTIONS AND COMPLICATIONS

- A. Not infectious disease-related
- 12  ..... 1. Acute hemolytic transfusion reaction, fatal, or other fatal reaction
- 13  ..... 2. Acute hemolytic transfusion reaction, nonfatal, or other significant transfusion reaction (e.g., DIC, anaphylaxis)
- 14  ..... a. Attributed to immune process
- 13  ..... i. ABO incompatibility
- 14  ..... ii. Other
- 15  ..... b. Attributed to non-immune process involving transfusion
- 15  ..... i. Hemolysis due to equipment failure  
(blood warming device, autologous transfusion device, etc.)
- 16  ..... ii. Hemolysis due to prior freezing or heating of transfused red cells
- 17  ..... iii. Hemolysis due to incorrect intravenous solution
- 18  ..... iv. Other unexpected reaction related to transfusion
- 19  ..... 3. Acute reaction, nonhemolytic, requiring significant intervention
- 20  ..... 4. Mistransfusion of a blood component – not resulting in an acute hemolytic reaction (e.g., ABO-compatible blood to the wrong patient)
- 21  ..... 5. Misadministration of a plasma derivative
- 22  ..... 6. Erroneous release by a transfusion service, not transfused
- 23  ..... 7. Graft-vs.-host disease attributed to transfusion
- B. Infectious disease-related
- 24  ..... 1. Septicemia attributed to transfusion
- 25  ..... 2. Any infection resulting from an error in procedure
- 26  ..... 3. HIV infection attributed to transfusion
- 27  ..... 4. Rare infection attributed to transfusion (includes HTLV, syphilis, malaria, babesiosis, Chagas' disease and others; does not include hepatitis B or C)

Name of reporting facility \_\_\_\_\_

Address of reporting facility

street

city

zip code

Details of incident (Attach separate sheet if necessary.)

Underlying causes/contributory factors

Corrective action taken, if any

Date of incident

month

day

year

Date of report

month

day

year

Person making report

Signature

Printed Name

Title

Telephone Number ( \_\_\_\_ )

Ensuring that the incident is reported is the responsibility of the director of the blood bank (collection service) for items in section I (and II, if applicable), and is the responsibility of the director of the transfusion service for items in section III (and II, if applicable). If corrective action is indicated, the appropriate director is responsible for ensuring that it is taken.

Submit within seven calendar days of the incident or its discovery to:

Dr. Jeanne Linden  
Blood Resources Program  
Wadsworth Center  
New York State Department of Health  
P.O. Box 509  
Albany, NY 12201-0509  
(518) 485-5361  
fax (518) 485-5342 (Please mail original)