

**New Jersey Department of Health
Clinical Laboratory Improvement Services
PO Box 361
Trenton, NJ 08625-0361**

BLOOD CENTERS - ANNUAL STATISTICAL DATA

Name of Blood Bank	County
Address	
Name of Individual Completing Form	Telephone Number

Please furnish the following data for the report year and return to the above address, by the due date given on the attached cover letter. Please retain a copy of the report for your files. If assistance is needed, contact the Blood Bank Program of the Clinical Laboratory Improvement Service at 609-406-6829.

A. SOURCES OF SUPPLY (Whole Blood and Packed Cells)	Totals
1. Number of units on hand January 1	
2. Number of allogeneic units drawn by your bank (incl. all stations)	
3. Number of allogeneic units drawn by your bank in New Jersey	
4. Number of double red cell procedures performed by your bank in New Jersey (allogeneic) (_____ x 2 = _____. Add total to number 3. above.)	////////////////////
5. Number of autologous units drawn by your bank in New Jersey	
6. Number of directed units drawn by your bank in New Jersey	
7. Number of units received from Red Cross	
8. Number of units received from New York Blood Center	
9. Number of units received from N. J. Community Blood Banks	
10. Number of commercial units received from commercial sources.	
11. No. of commercial units received directly from volunteer Blood Banks.	
12. Number of volunteer units received directly through the American Association of Blood Banks	
13. Number of commercial units received directly through the American Association of Blood Banks.	
14. Number of volunteer units received from Out-of-State Community Blood Banks.	
15. Number of volunteer units received from Out-of-State Red Cross Centers other than Penn Jersey	
TOTAL AVAILABLE SUPPLY	

**BLOOD CENTERS – ANNUAL STATISTICAL DATA
(Continued)**

Name of Blood Bank							
B. Distribution	Whole Blood			Packed Cells			Totals
	Allogeneic	Autologous	Directed	Allogeneic	Autologous	Directed	
1. Number of units supplied to:							
a. New Jersey Hospitals							
b. Out-of-State Hospitals							
c. N. J. Community Blood Banks							
d. Regional Red Cross Centers							
e. American Association of Blood Banks							
f. Federal and Military Institutions							
g. Other (specify):							
2. On Hand December 31							
C. Number of Units Discarded From:	Allogeneic		Autologous		Directed		Totals
	Your Collections	Other Sources	Your Collections	Other Sources	Your Collections	Other Sources	
1. Outdating							
2. Reactive HB _s Ag							
3. Reactive HB _c Ab							
4. Reactive Test for HCV Antibody							
5. Reactive for Syphilis							
6. Reactive Test for HIV Antibody							
7. Reactive HTLV-I/II							
8. Elevated ALT							
9. Irregular Antibodies							
10. Contamination, Breakage, etc.							
11. Donor Deferral Registry or Confidential Unit Exclusion							
12. Other (Specify) (e.g., equipment failure):							
TOTAL DISCARDS							
PERCENT DISCARDED							

**BLOOD CENTERS – ANNUAL STATISTICAL DATA
(Continued)**

Name of Blood Bank					
D. NUMBER OF UNITS IN SECTION C. ABOVE, CONFIRMED POSITIVE FOR:					
1. HIV					
2. HB _s Ag					
3. HCV					
4. STS					
E. BLOOD COMPONENTS	Number of Units				
	Prepared In Your Blood Bank	Obtained from Other Sources		Distributed to New Jersey Hospitals	Distributed to Out-of-State Hospitals
Name		Number			
1. Fresh frozen plasma					
2. Single Donor Platelets					
3. Platelet concentrates					
4. Cryoprecipitates					
5. Frozen red cells					
6. Washed red cells					
7. Prestorage leukoreduced RBC					
8. Leukocytes					
9. Other (Specify):					
F. APHERESIS/ THERAPEUTIC PHLEBOTOMY	Number of		Total Discarded	Distributed to	
	Donors	Units		NJ Hospitals	Out-or-State Hospitals
1. Plasmapheresis					
2. Leukapheresis					
3. Plateletpheresis					
4. Stem Cells					
5. Therapeutic Phlebotomy					

**BLOOD CENTERS – ANNUAL STATISTICAL DATA
(Continued)**

Name of Blood Bank			
G. SALVAGED PLASMA	Your Collections	Hospitals	Out-of-State
1. Number of Units Obtained From:			
2. Units Distributed to (Name)	Address		Amount (Liters)
a.			
b.			
c.			
d.			
e.			
f.			
TOTALS			
H. NUMBER AND TYPE OF DONOR REACTIONS	Slight	Moderate	Severe
1. Adverse Donor Reactions (Specify type, e.g., convulsions, etc.): *			
a. Number of Donors Transported to the Emergency Room	//////////	//////////	

* If you need additional space, please attach additional sheets.

Name of Blood Bank Director (Print)	Telephone Number
Signature of Blood Bank Director	Date