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

BLOOD BANK ANNUAL STATISTICS

(Out of Hospital and "Emergency Only" Transfusion Facilities)

Name of Facility	**CALENDAR YEAR**
Street Address	County
City, State, Zip Code	
Name of Individual Completing Form	Telephone Number

Please furnish the following data for the report year and return to the Department at the above address. For a response of zero, please indicate as such. Please retain a copy for your files. If you have any questions or if you need an extension for returning the report form, please contact the Clinical Laboratory Improvement Service, Blood Bank Unit, at 609-406-6829.

A. SOURCES OF SUPPLY

Name of Source Blood Bank(s) or Transfusion Service(s) you obtained blood and blood components from:

1. ______________________________
2. ______________________________
3. ______________________________

B. USAGE	**Received**	**Transfused**
1. Packed Red Blood Cells		
2. Platelets (Single Donor)		
3. Platelets (Random)		
4. Fresh Frozen Plasma		
5. Other		

C. MISCELLANEOUS

1. Number of Suspected Transfusion Reactions detected: ____________

   -If any, specify the type of reaction(s): ______________________

   -If any, did you notify the source blood bank? ☐ Yes ☐ No

   -Name of Source Blood Bank: ______________________

Name of Medical Director (Print)	
Signature of Medical Director	Date

CL-8
JUL 12