IRISH BLOOD TRANSFUSION SERVICE

COMPLAINT/DEFECT REPORT FORM

Irish Blood Transfusion Service
Seirbhís Fuilaistriúcháin Eireann

For completion by reporting hospital in the event of a complaint/defect with Blood Product or Service.
To report Adverse Transfusion Reactions wher IBTS has performed compatibility testing use BT311

To: National Quality Assurance Manager, IBTS, NBC, James's St., Dublin 8. QC/_____/____/IBTS
Or scan and email to qualityassurance@ibts.ie

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Hospital: _____ Department: _____

Name of person reporting: _____

COMPLAINT/DEFECT/DETAILS:

- **Product:** _____ Donation/Batch No.: _____

  Date of Expiry: _____ Date of observation/occurrence: _____

- **Service :** _____ Order Type: Routine / Emergency

Nature of Complaint/Defect:.....

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.....

Did Complaint/Defect result in delay in transfusion? _____

Comments:.....

.....

Signature: ..... Date: .....

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FOR COMPLETION BY IBTS

Date Received: _____ Received by: _____

Complaint/Defect Report No.: _____ Recall No._____

Initial Proposed Grade: Critical / Major / Moderate / Minor / Negligible

Referred on: Yes / No Referred to :_____ Date and Time referred: _____

Completed by: _____