Transfusion Report Form

HOSPITAL USE ONLY
DATE _____ **HOSPITAL NAME** _____
Prepared By: _____

COMPONENTS TRANSFUSED		
Unit Number	Product Code Number	Comments
Blood Center Use	Initial and date indicating that information has been entered:	

Fax form to your distribution center:

- Sioux City: 1-712-252-1013
- Des Moines: 1-515-288-4683
- Mason City: 1-641-424-4190
- Waterloo: 1-319-433-0464