

Wadsworth Center
Empire State Plaza
Albany, New York 12237

Facility name/city _____ Facility ID # _____
Date of discovery _____ Facility incident number _____
Date of occurrence _____ Time of occurrence _____ AM PM
Date of report _____
Person filing report _____ Title _____
Telephone number _____ Email address _____

Incident summary (attach a separate page if necessary)

Patient effect(s)

- Not applicable
- No effect apparent
- Fatality – likely related to HPC transplantation
- Fatality – possibly related to HPC transplantation, cause to be determined
- Infectious disease transmission (specify) _____
- Sepsis
- Specimen mixup
- Other (specify) _____

Donor effect(s)

- Not applicable
- No effect apparent
- Significant donor reaction (specify) _____
- Other (specify) _____

At what point(s) in the process did the incident occur?

- | | | |
|---|---|---|
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> Product storage | <input type="checkbox"/> Product issuance |
| <input type="checkbox"/> Donor history | <input type="checkbox"/> Sample collection/labeling | <input type="checkbox"/> Product administration |
| <input type="checkbox"/> Donor testing | <input type="checkbox"/> Test/product order | <input type="checkbox"/> Equipment function |
| <input type="checkbox"/> HPC collection | <input type="checkbox"/> Patient sample testing | |
| <input type="checkbox"/> HPC processing | <input type="checkbox"/> Documentation | |
| <input type="checkbox"/> Product labeling | <input type="checkbox"/> Product selection | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Product check-in | <input type="checkbox"/> Request for pick-up | |
| <input type="checkbox"/> Product manipulation | <input type="checkbox"/> Product labeling for issue | _____ |

Wadsworth Center
Empire State Plaza
Albany, New York 12237

How was the incident discovered? (check one)

- | | |
|---|--|
| <input type="checkbox"/> Bedside patient identification | <input type="checkbox"/> External audit |
| <input type="checkbox"/> Donor/recipient reaction | <input type="checkbox"/> Computer warning |
| <input type="checkbox"/> Supervisory review | <input type="checkbox"/> Historical record check |
| <input type="checkbox"/> Microbial testing | <input type="checkbox"/> Discordant lab results |
| <input type="checkbox"/> Subsequent HPC donation | <input type="checkbox"/> Review of order |
| <input type="checkbox"/> Internal Audit | <input type="checkbox"/> Reported by consignee |
| <input type="checkbox"/> Other (specify) _____ | |

Where did the incident occur? (check all that apply)

- Collection/recovery site HPC processor Storage facility Transplantation facility
 Other _____

Job function of the worker(s) involved in the incident (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Clinical laboratory technologist | <input type="checkbox"/> Registered nurse | <input type="checkbox"/> House staff |
| <input type="checkbox"/> HPC Recovery staff | <input type="checkbox"/> Clerical/administrative staff | <input type="checkbox"/> Attending physician |
| <input type="checkbox"/> HPC Processing staff | | |
| <input type="checkbox"/> Other (specify) _____ | | |

Product involved (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Peripheral blood stem cells | <input type="checkbox"/> Allogeneic donation |
| <input type="checkbox"/> Cord blood | <input type="checkbox"/> Autogeneic donation |
| <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> Directed donation |
| <input type="checkbox"/> Other (specify) _____ | |

Quantity distributed/issued

- None
 # of units _____

Quantity transplanted

- None
 # of units _____

Were affected HPCs distributed to New York?

- Yes No (If yes, identify facility)

Wadsworth Center

Empire State Plaza
Albany, New York 12237

Results of Investigation (attach a separate page, if necessary)

Was a root cause analysis performed? Yes No

Findings:

Corrective action (attach a separate page if necessary)

This form is a PDF fillable document. It is possible to enter data and save the document multiple times, even if you have only Adobe Reader. **Please send the completed PDF form, as an e-mail attachment, to BTRAXESS@health.ny.gov, with a subject title of Incident Report and your Facility ID number.** Alternatively, it can be faxed to 518-485-5342 or mailed to the Tissue Resources Program at the address above. Questions should be directed to the Tissue Resources Program at (518) 485-5341.