COMMUNITY BLOOD COUNCIL OF NEW JERSEY, INC.
1410 Parkside Avenue | Trenton, NJ 08638
Toll Free: 1-609-883-9750 | www.GiveBloodNJ.org

Hospital Return

Return Instructions:

1. Complete the Facility information and Component Information section of this form.
2. Sign to verify that the component(s) were **maintained** and **shipped** at the appropriate storage temperature.

Shipping ID#:
Consignee Signature:

Facility Information:

Facility Name:
Facility Address:
Phone Number:
Return Authorization Approval Name:
Form Completed by:

Component Information:

Unit #	Product Code	Expiration Date	Blood Type	Reason for return (see below)

Product Classes:

Leuko Reduced Red Blood Cells
Fresh Frozen Plasma
Salvage Plasma
Whole Blood
Platelets
Cryoprecipitate
Cryo poor FFP
24 Hour Recovered Plasma

Return Reasons:

Component not requested
Outdate
Recall/Withdrawal request
Segments needed
Irradiation needed
Broken Bag
Lipemic
Greenish
Other please specify:_____

Delivered By: _____ Date: _____