##

## REPORT OF SUSPECTED TRANSFUSION REACTION

**1. FOLLOW THE STEPS BELOW:**

* **STOP THE TRANSFUSION and verify information below**

**INFUSION RECORD:**

To be completed and signed by individual STOPPING Transfusion

 Yes No The identity of the patient agrees with the Name and MR # on the patient’s armband.

 Yes No The Name and MR# on the Blood Bank tag agree with those on the patient's armband.

 Yes No The ABO and Rh types on the Blood Bank tag agree with those on the product label.

 Yes No The Donor Number on the attached tag agrees with the Donor Number on the product label.

1. **SYMPTOMS OF THE SUSPECTED REACTION:**

|  |
| --- |
| **Patient Data** |
| **Vital Signs** | **Pre-Transfusion** | **Post-Transfusion** | **Check all that apply:** Chills Fever (1°C or 2°F rise in temperature) Flushing  Urticaria Hypotension Hypertension Dyspnea  Chest Pain Rigors Tachycardia Back Pain  Heat / Pain at the IV site Bleeding  Hemoglobinuria Oliguria Jaundice  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Time** |  |  |
| **Temperature** |  |  |
| **Blood Pressure** |  |  |
| **Pulse** |  |  |
| **Respiratory**Rate |  |  |
| **O2 Sat.** |  Room Air O2 Therapy\_\_\_\_\_\_ L/min |  Room Air O2 Therapy\_\_\_\_\_\_ L/min |

### GIVE A BRIEF DESCRIPTION OF THE REACTION:

### 3. DONOR BLOOD SUSPECTED OF CAUSING REACTIONS

DONOR #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_COMPONENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VOLUME TRANSFUSED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TRANSFUSION START DATE\_\_\_\_\_\_\_\_\_\_ TIME\_\_\_\_\_\_\_\_\_\_ TRANSFUSION STOP DATE\_\_\_\_\_\_\_\_\_\_ TIME\_\_\_\_\_\_\_\_\_\_

**4. REPORT all reactions to patient's physician:**

Name of Physician(s) Notified:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Action taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **PATIENT HISTORY**:

Previous Transfusions? YES NO Previous Reactions? YES NO

#### Was patient pretreated for transfusion? YES, Time:\_\_\_\_\_ NO Pretreatment Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### **6. Send the following to the Blood Bank FOR ALL REPORTED TRANSFUSION REACTIONS:**

1. 5 mL blood specimen in an EDTA (dark lavender top) tube labeled with:
	* Patient Name, Medical Record Number, Date, Phlebotomist Signature, The note “POST REACTION”
	* Phlebotomist: Signature/Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time Drawn\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. The blood product with attached recipient set and IV solutions.
3. **A COPY OF THIS COMPLETED FORM. PLACE THE ORIGINAL IN THE PATIENT’S MEDICAL RECORD**

**7. FORM COMPLETED BY: Signature/Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## SUSPECTED TRANSFUSION REACTION-BLOOD BANK REPORT

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient's Pretransfusion Records:**

ABO & Rh: Crossmatch: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_\_\_\_\_\_\_Time Issued: \_\_\_\_\_\_\_

**Returned Product Record: BLOOD BAG**

Component Amount Returned Expiration Date Compatibility Label on Product : Yes No

ABO &Rh\_\_\_\_\_\_\_\_\_\_Donor #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appearance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Check blood product for bacterial contamination (i.e. peculiar odor, brownish or purple color, clots, or abnormal masses in bag).

 Blood product bag sent for culture if contamination is suspected or if any of the following clinical indicators are present:

 shock

 hypertensive (systolic rises > 30mm Hg)

 hypotensive (systolic falls > 30mm Hg)

 fever (2ºC or 3.5ºF rise in temperature)

 rigors (shaking chills)

 tachycardia (heart rate is > 120/min, or rises > 40/minabove pre-transfusion rate).

Physician Notified of potential contamination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials: \_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_

PATIENT CULTURE Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## COMPATIBILITY LABEL

Patient ABO & Rh \_ Donor ABO & Rh\_\_\_\_\_\_\_ Donor # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MR #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Patient's Specimen:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Order Number | Label OK | Visual Hemolysis Check (Pos/Neg) | -A | -B | -D | A1C | BC | Interpretation | IgG | C3d 10' |
| PRE |  |  |  |  |  |  |  |  |  |  |  |
| POST |  |  |  |  |  |  |  |  |  |  |  |

Other Results/Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Results Reported to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tech:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gram Stain Results if indicated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CultureResults if indicated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUPERVISOR REVIEW\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BLOOD BANK RESIDENT REVIEW: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.D. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### BLOOD BANK MEDICAL DIRECTOR REVIEW: M.D. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_