

REPORT OF SUSPECTED TRANSFUSION REACTION

BLOODWORKS

CENTRAL	Ph. (206) 292-6525	FAX (206) 343-1780	TECH ID	BW ORDER #	TIME RECEIVED
OVERLAKE	Ph. (425) 467-3374	FAX (425) 688-5031			
EVERGREEN	Ph. (425) 434-4949	FAX (425) 899-7524			
SKL	Ph. (425) 656-7900	FAX (425) 255-0166			

NOTE: TRANSFUSION REACTION EVALUATIONS SHOULD BE TREATED AS AN EMERGENCY AND REPORTED IMMEDIATELY.

Instructions:

- Stop Transfusion. Do not discard unit or infusion set.
- Notify patient's MD.
- Maintain IV access.
- Monitor vital signs frequently.
- Perform clerical check.

1. Name & MRN on **Transfusion Report** agree with **patient's identification band?** Yes No

2. The blood bag number and ABO-Rh on **Transfusion Report** agree with the information on the **blood bag label?** Yes No

If no, explain: _____

Determine if samples (blood & urine) needed*

***BW requires sample for all reactions, except those with hives only. *Check your hospital policy.**

- Blood: Send 1 or 2 EDTA samples as specified by your policy to the hospital lab STAT with this form.
- Urine: Send red/dark urine to the hospital laboratory. Was urine sent? Yes No
- No samples: Hives only*

If samples sent, send the blood bag, infusion set, and any attached IV fluids with this form to BW.

Person Reporting: _____ Last, First (Legible)	Phone Results to: _____ Physician or Nurse: Last, First (Legible)
Patient's Physician: _____ Last, First (Legible)	Service or Unit: _____
Patient's Diagnosis: _____	Telephone Number (10 digit): _____

IMPLICATED UNIT NUMBER(S)	Pre Medication:
Hand write unit number(s) here	<input type="checkbox"/> Tylenol
Affix Unit Number Stickers(s) Here (if available)	<input type="checkbox"/> Benadryl
	<input type="checkbox"/> Other: _____

<p>Component: <input type="checkbox"/> Red Blood Cells <input type="checkbox"/> Cryoprecipitate</p> <p><input type="checkbox"/> Plasma <input type="checkbox"/> Whole Blood</p> <p><input type="checkbox"/> Platelets <input type="checkbox"/> Other: _____</p> <p>Amount infused (est.): _____</p> <p>Time and Vital Signs:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2"><u>Start of Transfusion</u></td> <td colspan="2"><u>Time of Reaction</u></td> </tr> <tr> <td>Date:</td> <td>Time:</td> <td>Date:</td> <td>Time:</td> </tr> <tr> <td>BP</td> <td></td> <td>BP</td> <td></td> </tr> <tr> <td>P</td> <td></td> <td>P</td> <td></td> </tr> <tr> <td>T</td> <td></td> <td>T</td> <td></td> </tr> <tr> <td>R</td> <td></td> <td>R</td> <td></td> </tr> <tr> <td>O₂ Sat</td> <td></td> <td>O₂ Sat</td> <td></td> </tr> </table> <p>Date & Time Specimen Collected (if done*): _____</p> <p>Person Drawing Specimen: (Print Last, First & Signature) _____</p> <p>Person Verifying Patient I.D.: (Print Last, First & Signature) _____</p>	<u>Start of Transfusion</u>		<u>Time of Reaction</u>		Date:	Time:	Date:	Time:	BP		BP		P		P		T		T		R		R		O ₂ Sat		O ₂ Sat		<p>Signs and Symptoms (new onset with or after transfusion)</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezes <input type="checkbox"/> Dark/Red Urine <input type="checkbox"/> Other: _____ </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Persistent Severe Hypoxia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Back or Chest Pain <input type="checkbox"/> Mechanical Ventilation/Intubation </td> </tr> </table> <p style="color: red;">Is the patient now back to baseline for the six symptoms listed above?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="color: red;">If no, explain: _____</p> <p>Hospital Laboratory:</p> <p>Centrifuged EDTA tube reveals hemolysis? <input type="checkbox"/> Yes <input type="checkbox"/> No N/A*</p> <p>Tech Initials: _____ Date & Time: _____</p> <p><input type="checkbox"/> Routed to Blood Center at Date & Time: _____</p>	<input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezes <input type="checkbox"/> Dark/Red Urine <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Persistent Severe Hypoxia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Back or Chest Pain <input type="checkbox"/> Mechanical Ventilation/Intubation
<u>Start of Transfusion</u>		<u>Time of Reaction</u>																													
Date:	Time:	Date:	Time:																												
BP		BP																													
P		P																													
T		T																													
R		R																													
O ₂ Sat		O ₂ Sat																													
<input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezes <input type="checkbox"/> Dark/Red Urine <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Persistent Severe Hypoxia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Back or Chest Pain <input type="checkbox"/> Mechanical Ventilation/Intubation																														

Immediately send one EDTA tube (if needed*), the blood bag, infusion set with attached IV fluids and this form to BW

Note: Name must exactly match the name on Sample Label

FOR BLOODWORKS USE ONLY

Name on sample	Last	First	M.I.
Medical Record Number			
Hospital/Institution			
Social Security Number	Sex (M/F)	Date of Birth (mm/dd/yr)	

REPORT OF SUSPECTED TRANSFUSION REACTION

BLOODWORKS

CENTRAL	Ph. (206) 292-6525	FAX (206) 343-1780	TECH ID	BW ORDER #	TIME RECEIVED
OVERLAKE	Ph. (425) 467-3374	FAX (425) 688-5031			
EVERGREEN	Ph. (425) 434-4949	FAX (425) 899-7524			
SKL	Ph. (425) 656-7900	FAX (425) 255-0166			

NOTE: TRANSFUSION REACTION EVALUATIONS SHOULD BE TREATED AS AN EMERGENCY AND REPORTED IMMEDIATELY.

Instructions:

- Stop Transfusion. Do not discard unit or infusion set.
- Notify patient's MD.
- Maintain IV access.
- Monitor vital signs frequently.
- Perform clerical check.
 - 1. Name & MRN on **Transfusion Report** agree with **patient's identification band**? Yes No
 - 2. The blood bag number and ABO-Rh on **Transfusion Report** agree with the information on the **blood bag label**? Yes No
- If no, explain: _____
- Determine if samples (blood & urine) needed*
 - *BW requires sample for all reactions, except those with hives only. *Check your hospital policy.**
 - Blood: Send 1 or 2 EDTA samples as specified by your policy to the hospital lab STAT with this form.
 - Urine: Send red/dark urine to the hospital laboratory. Was urine sent? Yes No
 - No samples: Hives only*
- If samples sent, send the blood bag, infusion set, and any attached IV fluids with this form to BW.

Person Reporting: _____ Last, First (Legible)	Phone Results to: _____ Physician or Nurse: Last, First (Legible)
Patient's Physician: _____ Last, First (Legible)	Service or Unit: _____
Patient's Diagnosis: _____	Telephone Number (10 digit): _____

IMPLICATED UNIT NUMBER(S)	Pre Medication:
Hand write unit number(s) here	<input type="checkbox"/> Tylenol
Affix Unit Number Stickers(s) Here (if available)	<input type="checkbox"/> Benadryl
	<input type="checkbox"/> Other: _____

<p>Component: <input type="checkbox"/> Red Blood Cells <input type="checkbox"/> Cryoprecipitate</p> <p> <input type="checkbox"/> Plasma <input type="checkbox"/> Whole Blood</p> <p> <input type="checkbox"/> Platelets <input type="checkbox"/> Other: _____</p> <p>Amount infused (est.): _____</p> <p>Time and Vital Signs:</p> <table style="width:100%; border: none;"> <tr> <td colspan="2"><u>Start of Transfusion</u></td> <td colspan="2"><u>Time of Reaction</u></td> </tr> <tr> <td>Date:</td> <td>Time:</td> <td>Date:</td> <td>Time:</td> </tr> <tr> <td>BP</td> <td></td> <td>BP</td> <td></td> </tr> <tr> <td>P</td> <td></td> <td>P</td> <td></td> </tr> <tr> <td>T</td> <td></td> <td>T</td> <td></td> </tr> <tr> <td>R</td> <td></td> <td>R</td> <td></td> </tr> <tr> <td>O₂ Sat</td> <td></td> <td>O₂ Sat</td> <td></td> </tr> </table> <p>Date & Time Specimen Collected (if done*): _____</p> <p>Person Drawing Specimen: (Print Last, First & Signature)</p> <p>_____</p> <p>Person Verifying Patient I.D.: (Print Last, First & Signature)</p> <p>_____</p>	<u>Start of Transfusion</u>		<u>Time of Reaction</u>		Date:	Time:	Date:	Time:	BP		BP		P		P		T		T		R		R		O ₂ Sat		O ₂ Sat		<p>Signs and Symptoms (new onset with or after transfusion)</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezes <input type="checkbox"/> Dark/Red Urine <input type="checkbox"/> Other: _____ _____ _____ </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Persistent Severe Hypoxia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Back or Chest Pain <input type="checkbox"/> Mechanical Ventilation/Intubation </td> </tr> </table> <p style="color: red;">Is the patient now back to baseline for the six symptoms listed above?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="color: red;">If no, explain: _____</p> <p>_____</p> <p>Hospital Laboratory:</p> <p>Centrifuged EDTA tube reveals hemolysis? <input type="checkbox"/> Yes <input type="checkbox"/> No N/A*</p> <p>Tech Initials: _____ Date & Time: _____</p> <p><input type="checkbox"/> Routed to Blood Center at Date & Time: _____</p>	<input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezes <input type="checkbox"/> Dark/Red Urine <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Persistent Severe Hypoxia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Back or Chest Pain <input type="checkbox"/> Mechanical Ventilation/Intubation
<u>Start of Transfusion</u>		<u>Time of Reaction</u>																													
Date:	Time:	Date:	Time:																												
BP		BP																													
P		P																													
T		T																													
R		R																													
O ₂ Sat		O ₂ Sat																													
<input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezes <input type="checkbox"/> Dark/Red Urine <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Persistent Severe Hypoxia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Back or Chest Pain <input type="checkbox"/> Mechanical Ventilation/Intubation																														

Immediately send one EDTA tube (if needed*), the blood bag, infusion set with attached IV fluids and this form to BW

Note: Name must exactly match the name on Sample Label

Name on sample	Last	First	M.I.
Medical Record Number			
Hospital/Institution			
Social Security Number	Sex (M/F)	Date of Birth (mm/dd/yr)	

FOR BLOODWORKS USE ONLY