

**REPORT OF SUSPECTED TRANSFUSION REACTION**

**BLOODWORKS NORTHWEST**

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

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

**Instructions:**

- Stop Transfusion. Retain the unit with attached infusion set and IV solutions
- Notify patient's physician or a licensed provider.
- Maintain IV access.
- Monitor vital signs frequently.
- Perform clerical recheck between the patient and the component.
  1. Name & MRN on **Transfusion Report** agree with **patient's identification band?**  Yes  No
  2. The unit number and unit ABO-Rh on **Transfusion Report** agree with the information on the **blood bag label?**  Yes  No
 If not, 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 Bloodworks Northwest 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 Bloodworks Northwest.

Person Reporting: _____ <span style="margin-left: 100px;">Last, First (Legible)</span>	Phone Results to: _____ <span style="margin-left: 100px;">Physician or Nurse: Last, First (Legible)</span>
Patient's Provider: _____ <span style="margin-left: 100px;">Last, First (Legible)</span>	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><b>Component:</b> <input type="checkbox"/> Red Blood Cells      <input type="checkbox"/> Cryoprecipitate  <input type="checkbox"/> Plasma                                      <input type="checkbox"/> Whole Blood  <input type="checkbox"/> Platelets                                      <input type="checkbox"/> Other: _____</p> <p>Amount infused (est.): _____</p> <p><b>Time and Vital Signs:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: left;"><u>Start of Transfusion</u></th> <th colspan="2" style="text-align: left;"><u>Time of Reaction</u></th> </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>O<sub>2</sub> Sat</td> <td></td> <td>O<sub>2</sub> Sat</td> <td></td> </tr> </table> <p><b>Date &amp; Time Specimen Collected (if done*):</b> _____</p> <p>Person Drawing Specimen: (Print Last, First &amp; Signature)                  _____</p> <p>Person Verifying Patient I.D.: (Print Last, First &amp; 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 <sub>2</sub> Sat		O <sub>2</sub> Sat		<p><b>Signs and Symptoms (new onset during or after transfusion)</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Hives only*</td> <td><input type="checkbox"/> Anaphylaxis</td> </tr> <tr> <td><input type="checkbox"/> Hives</td> <td><input type="checkbox"/> Difficulty Breathing</td> </tr> <tr> <td><input type="checkbox"/> Fever (≥1°C rise to ≥38°C)</td> <td><input type="checkbox"/> Persistent Severe Hypoxia</td> </tr> <tr> <td><input type="checkbox"/> Shaking Chills</td> <td><input type="checkbox"/> Nausea/Vomiting</td> </tr> <tr> <td><input type="checkbox"/> Periorbital Edema</td> <td><input type="checkbox"/> Back or Chest Pain</td> </tr> <tr> <td><input type="checkbox"/> Wheezing</td> <td><input type="checkbox"/> Mechanical Ventilation/Intubation</td> </tr> <tr> <td><input type="checkbox"/> Dark/Red Urine</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table> <p style="color: red; font-weight: bold;">Is the patient now back to baseline for the six symptoms listed above?</p> <p style="color: red; font-weight: bold;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p style="color: red; font-weight: bold;">If not, explain:                  _____                  _____</p> <p><b>Hospital Laboratory:</b></p> <p>Centrifuged EDTA tube reveals hemolysis?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    N/A*</p> <p>Tech Initials: _____ Date &amp; Time: _____</p> <p><input type="checkbox"/> Routed to Blood Center at Date &amp; Time: _____</p>	<input type="checkbox"/> Hives only*	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Hives	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Fever (≥1°C rise to ≥38°C)	<input type="checkbox"/> Persistent Severe Hypoxia	<input type="checkbox"/> Shaking Chills	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Periorbital Edema	<input type="checkbox"/> Back or Chest Pain	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Mechanical Ventilation/Intubation	<input type="checkbox"/> Dark/Red Urine		<input type="checkbox"/> Other: _____	
<u>Start of Transfusion</u>		<u>Time of Reaction</u>																																											
Date:	Time:	Date:	Time:																																										
BP		BP																																											
P		P																																											
T		T																																											
R		R																																											
O <sub>2</sub> Sat		O <sub>2</sub> Sat																																											
<input type="checkbox"/> Hives only*	<input type="checkbox"/> Anaphylaxis																																												
<input type="checkbox"/> Hives	<input type="checkbox"/> Difficulty Breathing																																												
<input type="checkbox"/> Fever (≥1°C rise to ≥38°C)	<input type="checkbox"/> Persistent Severe Hypoxia																																												
<input type="checkbox"/> Shaking Chills	<input type="checkbox"/> Nausea/Vomiting																																												
<input type="checkbox"/> Periorbital Edema	<input type="checkbox"/> Back or Chest Pain																																												
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Mechanical Ventilation/Intubation																																												
<input type="checkbox"/> Dark/Red Urine																																													
<input type="checkbox"/> Other: _____																																													

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

Note: Name must exactly match the name on Sample Label

FOR BLOODWORKS USE ONLY

Name on sample    Last                      First                      M.I.	POC NOTIFIED NAME:
Medical Record Number	Quarantine co-components? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital/Institution	OK to give additional blood components? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number    Sex (M/F)                      Date of Birth (mm/dd/yr)	Tech ID: _____ Date: _____

**REPORT OF SUSPECTED TRANSFUSION REACTION**

**BLOODWORKS NORTHWEST**

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. Retain the unit with attached infusion set and IV solutions  Notify patient's physician or a licensed provider.
- Maintain IV access.
- Monitor vital signs frequently.
- Perform clerical recheck between the patient and the component.
  1. Name & MRN on **Transfusion Report** agree with **patient's identification band?**  Yes  No
  2. The unit number and unit ABO-Rh on **Transfusion Report** agree with the information on the **blood bag label?**  Yes  No
 If not, 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 Bloodworks Northwest 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 Bloodworks Northwest.

Person Reporting: _____ <span style="margin-left: 100px;">Last, First (Legible)</span>	Phone Results to: _____ <span style="margin-left: 100px;">Physician or Nurse: Last, First (Legible)</span>
Patient's Provider: _____ <span style="margin-left: 100px;">Last, First (Legible)</span>	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><b>Component:</b> <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><b>Time and Vital Signs:</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><u>Start of Transfusion</u></td> <td style="width:25%;"></td> <td style="width:25%;"><u>Time of Reaction</u></td> <td style="width:25%;"></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>O<sub>2</sub> Sat _____</td> <td></td> <td>O<sub>2</sub> Sat _____</td> <td></td> </tr> </table> <p><b>Date &amp; Time Specimen Collected (if done*):</b> _____</p> <p>Person Drawing Specimen: (Print Last, First &amp; Signature) _____</p> <p>Person Verifying Patient I.D.: (Print Last, First &amp; 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 <sub>2</sub> Sat _____		O <sub>2</sub> Sat _____		<p><b>Signs and Symptoms (new onset during or after transfusion)</b></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 (≥1°C rise to ≥38°C)  <input type="checkbox"/> Shaking Chills  <input type="checkbox"/> Periorbital Edema  <input type="checkbox"/> Wheezing  <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  <p style="color: red; font-size: small;">Is the patient now back to baseline for the six symptoms listed above?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No                      If not, explain: _____                      _____                 </td> </tr> </table> <p><b>Hospital Laboratory:</b></p> <p>Centrifuged EDTA tube reveals hemolysis? <input type="checkbox"/> Yes <input type="checkbox"/> No N/A*</p> <p>Tech Initials: _____ Date &amp; Time: _____</p> <p><input type="checkbox"/> Routed to Blood Center at Date &amp; Time: _____</p>	<input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever (≥1°C rise to ≥38°C) <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezing <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 <p style="color: red; font-size: small;">Is the patient now back to baseline for the six symptoms listed above?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No If not, explain: _____ _____
<u>Start of Transfusion</u>		<u>Time of Reaction</u>																													
Date: _____	Time: _____	Date: _____	Time: _____																												
BP _____		BP _____																													
P _____		P _____																													
T _____		T _____																													
R _____		R _____																													
O <sub>2</sub> Sat _____		O <sub>2</sub> Sat _____																													
<input type="checkbox"/> Hives only* <input type="checkbox"/> Hives <input type="checkbox"/> Fever (≥1°C rise to ≥38°C) <input type="checkbox"/> Shaking Chills <input type="checkbox"/> Periorbital Edema <input type="checkbox"/> Wheezing <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 <p style="color: red; font-size: small;">Is the patient now back to baseline for the six symptoms listed above?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No If not, explain: _____ _____																														

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

**Note: Name must exactly match the name on Sample Label**

FOR BLOODWORKS USE ONLY

Name on sample    Last                                      First                                      M.I.	POC NOTIFIED NAME:
Medical Record Number	Quarantine co-components? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital/Institution	OK to give additional blood components? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number      Sex (M/F)                                      Date of Birth (mm/dd/yr)	Tech ID: _____ Date: _____

TO REORDER FORM-00231 15 VISIT <https://tinyurl.com/bloodworks-forms-request>

**HOSPITAL COPY**