REPORT OF SUSPECTED TRANSFUSION REACTION

CHILDRENS Ph. 206-987-5151 FAX 206-987-9200 ACCESSION NUMBER DATE/TIME RECEIVED

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

Instructions:

- ☐ Stop transfusion immediately (maintain sterility; do not discard unit or infusion set.)
- ☐ Stay with the patient; ask for help.
- ☐ Notify patient's provider.
- ☐ Monitor vital signs frequently.
- ☐ Maintain IV access. (Do not flush existing line; use new IV tubing if required).
- ☐ Do not give additional blood products until transfusion reaction work-up is complete, except for hives only and life-saving emergency transfusion.
- ☐ Perform an additional check of:
  1. Name & MRN on **Transfusion Report** agree with **patient's identification band?** ☐ Yes ☐ No
  2. The blood bag number and ABO/RhD on **Transfusion Report** agree with the information on the **blood bag label?** ☐ Yes ☐ No

  If no, explain: _____
- ☐ Determine if samples (blood & urine) are needed*

  ***Sample required for all reactions, except those with hives only.**
  - ☐ Blood: Send 1 EDTA sample STAT with this form to the Transfusion Service.
  - ☐ Urine: Send red/dark urine to the hospital laboratory. Was urine sent? ☐ Yes ☐ No
  - ☐ No sample: Hives only* (Transfusion may be restarted after hives subside)
- ☐ If samples sent, send the blood bag, infusion set, and any attached IV fluids with this form to the Transfusion Service.

Person Reporting: _____
Last, First (Legible)

Patient's Physician: _____
Last, First (Legible)

Patient's Diagnosis: _____

Phone Results to: _____
Physician or Nurse: Last, First (Legible)

Service or Unit: _____

Telephone Number _____

IMPLICATED UNIT NUMBER(S)

Hand write unit number(s) here

Affix Unit Number Stickers(s) Here (if available)

Pre Medication:
- ☐ Tylenol
- ☐ Benadryl
- ☐ Other: _____

Component: ☐ Red Blood Cells ☐ Cryoprecipitate ☐ Plasma ☐ Whole Blood ☐ Platelets ☐ Other: _____

Amount infused (est.): _____

Time and Vital Signs:

Start of Transfusion		Time of Reaction	
Date:	Time:	Date:	Time:
BP		BP	
P		P	
T		T	
R		R	
O_2 Sat		O_2 Sat	

Date & Time Specimen Collected (if done*): _____
DATE / TIME

Person Drawing Specimen: (Print Last, First & Signature)

_____

Person Verifying Patient I.D.: (Print Last, First & Signature)

_____

Signs and Symptoms (new onset with or after transfusion)

- ☐ Hives only
- ☐ Hives
- ☐ Fever
- ☐ Shaking Chills
- ☐ Periorbital Edema
- ☐ Wheezes
- ☐ Dark/Red Urine
- ☐ Other: _____
- ☐ Anaphylaxis
- ☐ Difficulty Breathing
- ☐ Persistent Severe Hypoxia
- ☐ Nausea/Vomiting
- ☐ Back or Chest Pain
- ☐ Mechanical Ventilation/Intubation

Is patient now back to baseline?
☐ Yes ☐ No
If no, explain: _____

FOR TRANSFUSION SERVICE USE ONLY:

Hemolysis? ☐ Positive ☐ Negative ☐ N/A
Post-DAT result ☐ Positive ☐ Negative ☐ N/A
Pre-DAT result ☐ Positive ☐ Negative ☐ N/A
ABO RhD match ☐ Yes ☐ No
Quarantine? ☐ Yes ☐ No
If yes, contact blood supplier.
Cultured? ☐ Yes ☐ No ☐ N/A
Okay to receive more products? ☐ Yes ☐ No

Note: Name must exactly match the name on Sample Label

Name on sample *Last* *First* *Middle*

Medical Record Number

POC notified _____

Tech ID: _____ Date/Time: _____