REPORT OF SUSPECTED TRANSFUSION REACTION

BLOODWORKS

CENTRAL	Ph. (206) 292-6525	FAX (206) 343-1780
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

TECH ID	BW ORDER #	TIME RECEIVED

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)

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

Patient's Diagnosis: _____

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

Service or Unit: _____

Telephone Number (10 digit): _____

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
- ☐ Plasma
- ☐ Platelets
- ☐ Cryoprecipitate
- ☐ Whole Blood
- ☐ 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*): _____

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 the patient now back to baseline for the six symptoms listed above?

☐ Yes ☐ No

If no, explain: _____

Hospital Laboratory:

Centrifuged EDTA tube reveals hemolysis? ☐ Yes ☐ No N/A*

Tech Initials: _____

☐ Routed to Blood Center at Date & Time: _____

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)*

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