REPORT OF	SUS	SPEC	CTED TRA	NSFUSI	ON REACTION			<b>BLOODWORKS</b>				
CENTRAL	Ph	(206	) 292-6525	FAX (206	343-1780	TECH ID	BW ORDER #	TIME RECEIVED				
OVERLAKE			) 467-3374		) 688-5031							
EVERGREEN			) 434-4949	•	899-7524							
SKL	Ph	. (425	) 656-7900	FAX (425	) 255-0166 NO		E: TRANSFUSION REACTION EVALUATIONS SHOULD BE TREATED AS AN EMERGENCY AND REPORTED IMMEDIATELY.					
Instructions:			Stop Trans	sfusion. Do	not discard unit or infusio	n set.						
			Notify patie	ent's MD.								
			Maintain I\	/ access.								
			Monitor vit	al signs fred	uently.							
			Perform cl	erical check								
			1. Name 8	& MRN on <b>T</b>	ransfusion Report agree	with patient's identificat	ion band?	☐ Yes ☐ No				
				ood bag num		sfusion Report agree wit	h the information on	□ Yes □ No				
			If no, ex	xplain:								
			Determine	if samples (								
*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/da	ark urine to the hospital la	boratory. Was urine sent?	•	☐ Yes ☐ No				
			☐ No sam	nples: Hives	only*							
			If samples	sent, send	he blood bag, infusion se	t, and any attached IV fluid	ds with this form to B	BW.				
Person Reportin	na:					Phone Results to:						
	· 3·		Last, First (L	.egible)		Physician or Nurse: Last, First (Legible)						
Patient's Physic	ian:					Service or Unit:	Service or Unit:					
	_		Last, First (L	.egible)								
Patient's Diagno	osis:					Telephone Number (10 digit):						
<u>J</u>		IMPL	ICATED UNI	T NUMBER	(S)	Pre Medication:						
Hand write unit i	numbe	er(s) h	ere		· ,	☐ Tylenol						
Tiaria Willo anii		,,(0)	0.0		nit Number Stickers(s)	☐ Benadryl						
					Here (if available)	□ Other:						
Component: □	Red	Blood	Cells	□ Cryop	ecipitate	Signs and Symptoms	(new onset with or after	er transfusion)				
•	Plasi			□ Whole		☐ Hives only*	☐ Anaphylaxis					
	Plate	lets		☐ Other:		☐ Hives	☐ Difficulty Bre					
Amount infused	(oot ):					□ Fever	☐ Persistent S	=				
Amount infused								<b>,</b> ,				
Time and Vital	·	:				☐ Shaking Chills	□ Nausea/Von	ŭ				
Start of Transfus	sion			Time of R	eaction eaction	☐ Periorbital Edema	☐ Back or Che					
Date:		Time	:	Date:	Time:	☐ Wheezes	☐ Mechanical	Ventilation/Intubation				
BP				BP		☐ Dark/Red Urine		ow back to baseline for the six				
Р				Р		☐ Other:	symptoms listed	d above?				
Т				Т			_	0				
R				R			If no, explain:					
O <sub>2</sub> Sat				O <sub>2</sub> Sat			_					
Date & Time Sp	ecim	en Co	llected (if de	one*):		Hospital Laboratory:	ı					
Person Drawing			-	-	:0)	Centrifuged EDTA tube	rovoale homolysis?	P □ Yes □ No N/A*				
reison Diawing	Spec	iiieii.	(FIIII Last, FI	isi & Signatui	e)	Centinagea EDTA tabe	reveals hemolysis!	L les L No N/A				
Person Verifying Patient I.D.: (Print Last, First & Signature)						Tech Initials:						
				DTA (ob a /		Routed to Blood Center at Date & Time:						
				•	•	Ť						
			xactly matc		on Sample Label	FC	OR BLOODWORKS	USE CINLY				
Name on sample	e La	ast		First	M.I.							
Medical Record	Numk	er										
Hospital/Instituti	ion											
Social Security I	Numb	er	Sex (M/I	=)	Date of Birth (mm/dd/yr)							

REPORT OF	SUSPEC	TED TRA	NSFUSIC	N REACTION			<b>BLOODWORKS</b>					
CENTRAL	Ph. (206)	292-6525	FAX (206)	343-1780	TECH ID	BW ORDER #	TIME RECEIVED					
OVERLAKE		467-3374	FAX (425)									
EVERGREEN	Ph. (425)		FAX (425)									
SKL	Ph. (425)	656-7900	FAX (425)	255-0166 <b>NOT</b>	: TRANSFUSION REACTION EVALUATIONS SHOULD BE TREATED AS AN EMERGENCY AND REPORTED IMMEDIATELY.							
Instructions:		Stop Trans										
		Notify patie	ent's MD.									
		Maintain IV	access.									
			al signs frequ	iently.								
		Perform cle										
				ansfusion Report agree	•		□ Yes □ No					
		the <b>bloc</b>	od bag labe		, ,		□ Yes □ No					
		-										
☐ 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.												
				k urine to the hospital lab	oratory. Was urine sent?	?	□ Yes □ No					
	_		ples: Hives									
		If samples	sent, send th	ne blood bag, infusion set,	and any attached IV fluid	ds with this form to B	3W.					
Person Reportin					Phone Results to:							
	L	ast, First (Lo	egible)		Physician or Nurse: Last, First (Legible)  Service or Unit:							
Patient's Physic												
	L	ast, First (Lo	egible)									
Patient's Diagno	osis:				Telephone Number (10 digit):							
	IMPLI	CATED UNI	T NUMBER(	S)	Pre Medication:							
Hand write unit i	number(s) he	ere	Affice I Im	it Number Ctickers(s)	☐ Tylenol							
				it Number Stickers(s) lere (if available)	☐ Benadryl ☐ Other:							
Component: □		Cells	☐ Cryopre		Signs and Symptoms	(new onset with or after	er transfusion)					
	Plasma		□ Whole		☐ Hives only*	□ Anaphylaxis						
	Platelets		☐ Other:		☐ Hives	☐ Difficulty Bre	eathing					
Amount infused	(est.):				☐ Fever	□ Persistent S	evere Hypoxia					
Time and Vital	Signs:				☐ Shaking Chills	□ Nausea/Von	niting					
Start of Transfus	sion		Time of Re	action	☐ Periorbital Edema	☐ Back or Che	est Pain					
Date:	Time:		Date:	Time:	☐ Wheezes	☐ Mechanical	Ventilation/Intubation					
BP			BP		☐ Dark/Red Urine		ow back to baseline for the six					
P			P		☐ Other:	symptoms listed						
Т			' T		L Other.	☐ Yes ☐ No						
R			R		-							
						ii no, expiain						
O <sub>2</sub> Sat			O <sub>2</sub> Sat		-	_ I <del></del>						
Date & Time Sp	ecimen Col	lected (if do	one*):		Hospital Laboratory:							
Person Drawing	Specimen:	(Print Last, Fir	rst & Signature	e)	Centrifuged EDTA tube reveals hemolysis? ☐ Yes ☐ No N/A*							
					Table to Wales							
Person Verifying	Patient I.D.:	(Print Last, F	First & Signatu	re)	Tech Initials:							
, ,		,	Ü	,	☐ Routed to Blood Ce	enter at Date & Time:	:					
Ir	mmediately	send one E	DTA tube (if	needed*), the blood bag			-					
Note: Na	ame must ex	actly match	h the name	on Sample Label	FC	OR BLOODWORKS	USE ONLY					
Name on sample			First	M.I.								
Medical Record	Number											
Hospital/Instituti	ion											
Social Security I	Number	Sex (M/F	-) <u>[</u>	Date of Birth (mm/dd/yr)								