



Transfusionist Must:

1. Stop blood infusion. Keep IV open with saline drip.
2. Notify Physician
3. Notify Blood Bank
4. Send completed form, blood bag with attached tubing and IV fluid, post reaction blood specimen (lavender top) to Blood Bank.
5. Collect immediate post reaction urine and send to Blood Bank ASAP
6. Additional blood may not be infused until the reaction work up has been completed.

Part A: Complete All Information

Date :	Product:	Unit Number:
Time Infusion Started:	Time Infusion Stopped:	
Pretransfusion Temperature:	Post Transfusion Temperature:	
Pretransfusion BP:	Post Transfusion BP:	
Estimated volume of blood infused:		
Date and Time Physician Notified:	Name of Physician:	
Does the name and medical record number on the patient's armband and the component tag match? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medication given during transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list names and routes of administration:		

Part B: Check All Symptoms That Apply:

<input type="checkbox"/> Urticaria, itching	<input type="checkbox"/> Severe bilateral pulmonary edema
<input type="checkbox"/> Facial swelling	<input type="checkbox"/> Tachycardia
<input type="checkbox"/> Chills	<input type="checkbox"/> Breathing difficulty
<input type="checkbox"/> Headache	<input type="checkbox"/> Severe apprehension
<input type="checkbox"/> Increase in temperature 1 ⁰ C or 2 ⁰ F	<input type="checkbox"/> Burning along infusion vein
<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Significant back pain
<input type="checkbox"/> Severe rigors	<input type="checkbox"/> Shock
<input type="checkbox"/> Hypotension	<input type="checkbox"/> Hematuria
<input type="checkbox"/> Dry, flushed skin	<input type="checkbox"/> Bleeding, oozing from IV site /wound
<input type="checkbox"/> Abdominal cramping	<input type="checkbox"/> Oliguria
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Laryngeal/pharyngeal edema

Signature & Printed Name of RN Reporting Suspected Reaction

Date/Time

Physician Signature & Printed Name

Date/Time

Delayed Hemolytic Reaction (Requested by Physician or Laboratory)

<input type="checkbox"/> Unexplained drop in hemoglobin	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Post transfusion positive DAT	<input type="checkbox"/> Post transfusion anamnestic antibody response

