

Patient Label



Suspected Transfusion Reaction Notification and
Work-up Request

1. If you suspect a possible transfusion reaction, **STOP THE TRANSFUSION** immediately. Keep the intravenous line open (KVO) with a slow infusion of normal saline.
2. Notify the physician & Transfusion Services @ (743-4466) regarding patient management.
3. If localized hives, itching, or flushing are the only manifestations of the reaction, then the physician may order administration of an anti-histamine (e.g. diphenhydramine/Benadryl). If administration of an anti-histamine resolves these symptoms/signs, then you may restart the transfusion, as ordered by the physician. If these symptoms/signs reappear, then stop the transfusion completely, notify Transfusion Services@ (743-4466), and initiate a suspected transfusion reaction (TXRX) workup.
4. Initiate a suspected TXRX workup if the following signs or symptoms occur:
 - a. Generalized hives/urticarial, pruritus, flushing
 - b. Shortness of Breath/Dyspnea, wheezing, cyanosis
 - c. Facial swelling, periorbital edema, perioral edema, stridor
 - d. Fever (rise in temperature of 1.0C/2.0F with temperature \geq 38.2C or 100.6F), chills, shaking or rigors
 - e. Back/flank pain, abdominal pain, pain at site of IV insertion, anxiety
 - f. Hyper or Hypo tension, chest pain
 - g. Nausea/vomiting, headache
 - h. Sudden unexplained change in patient condition
5. As part of the workup, document the reaction in the Blood Products Transfusion Note in HIS or if during downtime complete the paper nurse flowsheet.
6. Secure the unit and administration set. Close tubing securely to prevent contamination. Place in plastic bag.
7. Return the patient sample, discontinued blood bag/infusion set (even if the transfusion is complete) with the copy of the Emergency Transfusion Record if not using electronic documentation for the transfusion the Transfusion Service.



REPORT OF SUSPECTED TRANSFUSION REACTION

SYMPTOMS
☐ FEVER OF 2° ABOVE PRETRANSFUSION TEMPERATURE

AMOUNT GIVEN 1/4 1/2 ALL

DID PATIENT EXPERIENCE FEBRILE EPISODES PRIOR TO TRANSFUSION? ☐ YES ☐ NO

<input type="checkbox"/> CHILLS	<input type="checkbox"/> HEMOGLOBINURIA	<input type="checkbox"/> DYSPNEA	<input type="checkbox"/> FLUSHING	<input type="checkbox"/> CHEST PAIN
<input type="checkbox"/> URTICARIA	<input type="checkbox"/> HYPOTENSION	<input type="checkbox"/> LOW BACK PAIN	<input type="checkbox"/> BURNING ALONG INFUSION SITE	
<input type="checkbox"/> OOZING FROM WOUND OR VENIPUNCTURE		<input type="checkbox"/> OTHER		

HAS PATIENT EXPERIENCED SIMILAR SYMPTOMS PRIOR TO TRANSFUSION? ☐ YES ☐ NO

1. STOP TRANSFUSION IMMEDIATELY, BUT KEEP IV OPEN.
2. COMPLETE TABLE
3. NOTIFY PATIENT PHYSICIAN

NAME/ID _____

BEEPER # _____

BY: _____ RN

4. TRANSFUSION REACTION INVESTIGATION REQUESTED BY PHYSICIAN ☐ YES ☐ NO

IF YES:
A) RETURN THIS FORM AND BLOOD BAG TOGETHER WITH ATTACHED IV SET AND SOLUTIONS TO BLOOD BANK.
B) DRAW A PINK TOP TUBE FROM A DIFFERENT SITE THAN THE INFUSION SITE, SEND TO BLOOD BANK.
C) COLLECT NEXT URINE SPECIMENT, SEND TO BLOOD BANK.

RECHECK AT BEDSIDE

FROM PT'S T-BAND

NAME

MRN

T-BAND

FROM FRONT OF COMPONENT TAG

NAME

UNIT BLOOD TYPE

MRN

UNIT #

T#

PATIENT BLOOD TYPE

FROM FRONT OF BLOOD COMPONENT

UNIT #

UNIT BLOOD TYPE

COMMENTS: _____