BLOOD PRODUCTS: TRANSFUSION FORM (PAPER)

Specimen Drawn and Labeled By: _____

Date: / / Time: : am /pm

Patient ABO/Rh Type:

Unit #:

Expiration Date:

Unit ABO/Rh Type:

Antibody Screen:

☐ Negative ☐ Positive

☐ See Comments Below

Crossmatch:

☐ Compatible
☐ Incompatible
☐ Not complete
☐ Not Required

Date:

Time:

Tech:

Comments:(Other Tests)

(1)

Armband ID _____

Patient Name:

Acct.#:

DOB:

Physician:

(2) Product Needed:

☐ Red Cells, Packed
☐ Platelet Pheresis (6 units)
☐ Fresh Frozen Plasma
☐ Other

(3)

Current signed Informed Consent Yes ☐ No ☐ Emerg ☐

Emergency Release Request

The Following Test Cannot Be Completed Prior To The Transfusion:

☐ Group & Type ☐ Crossmatch ☐ Antibody screen or Identification

I am fully aware of the possible complications from using this blood, but because of urgency, request its immediate release.

_____ _____ am / pm Date: ____/____/____

Ordering Physician

See back of form for signs and symptoms of transfusion reaction

Transfusion Record

Mark Box Below As Completed By Transfusionist Prior To Starting The Transfusion!

☐ Blood Warmer Used (Do Not Exceed 42º C) Temperature _____

☐ Blood Product Aministered in O.R.

☐ Transfusion instruction sheet has been explained and given to patient/family member.
☐ Physician order has been verified for correct component and amount to be given.
☐ Only 0.9% Sodium Chloride, injection (USP) may be added to or infused through the same tubing as blood or components.
☐ I have established the identity of the patient.
☐ ABO/Rh type and unit number on this form are identical with the unit label.
☐ Patient Name and Blood Bank ID number on this form and unit label are identical to those on the Blood Bank ID band on the patient.
☐ Transfusion has been started within 30 minutes of release of unit from Blood Bank.

I certify the above statements to be true:

Transfusionist (RN, Physician/Anesthesia provider) signature _____ RN Co-signature _____ Dateand Time _____

Refer to back of the form for any vital sign deviation exceeding the limits indicated in red

VS Recorded	Time	Temp	Pulse	Resp	B/P	Patient Assessment	Signature
		≥2° F rise or 1° C	< > 25	>10	< > 35	Notify RN/MD When Vital Signs Exceed Limit	
START							
15 min							
30 min							
1 hr							
1.5 hr							
2 hr							
2.5 hr							
3 hr							
3.5 hr							
4 hr							
Complete							
1 hr Post						☐ No signs or symptoms of transfusion reaction	

Return completed Yellow form and empty blood bag to Blood Bank. ☐ Entire Unit Given ☐ Partial Unit Given _____ cc

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Patient Label

If...	Then...
• Temperature rise of 2º F or 1º C • Shaking chills • Back pain (lumbar or flank pain) - new or worsening • Dyspnea (shortness of breath), wheezing or coughing - new or worsening • Chest pain - new or worsening • Strider or difficulty breathing - new or worsening • Pain or heat at the transfusion site or along the vein • Nausea, vomiting, diarrhea or abdominal cramps - new or worsening • Unexplained loss of consciousness • Unexplained signs of shock • Red urine or hematuria - new or worsening • Headache - new or worsening • Joint pain - new or worsening • Oozing or increased bleeding from wound • Flushing of skin - new or worsening • Death	1. The transfusion **MUST BE STOPPED IMMEDIATELY!** 2. Transfusion reaction investigation initiated a. Verify the patient's identity. If an error noted - notify Blood Bank IMMEDIATELY b. Notify the Blood Bank and the Attending Physician. c. Fill out Transfusion Reaction Investigation Form (LAB009) d. Obtain an immediate post-transfusion urine specimen and retrieve the blood transfusion unit with infusion set attached and sealed off. Do not return set if only IV access. 3. Lab will notify Medical Director 4. Lab will contact the Nursing Staff as to whether or not another unit is to be transfused based on the results of the transfusion reaction workup and the Medical Director.
If...	**Then...**
• Change in pulse from initial reading (either decrease or increase) **of greater than 25 beats per minute** • Change in Blood Pressure from initial reading (either increase or decrease in systolic or diastolic) **of greater than 35 mmHg** • Increased respirations from initial reading, **greater than 10 breaths per minute**	The transfusion MUST BE TEMPORARILY DISCONTINUED and the attending physician notified of the following symptoms. The attending physician must assess the hemodynamic status of the recipient to determine if symptoms are consistent with the patient's condition. If symptoms are unrelated to the patient's hemodynamic status, a transfusion reaction investigation is recommended.
• Urticarial (hives) reaction	NOT AN INDICATION FOR AUTOMATICALLY DISCONTINUING the transfusion; although it must be reported to the Blood Bank on Transfusion Reaction Investigation Form (LAB009). The patient should be treated for the urticarial reaction.

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