

**Louisiana State University Health Care Services Division
Medical Center of Louisiana at New Orleans**

**RECORD OF TRANSFUSION COMPLICATION
(TRANSFUSION REACTION)**

**This form to be completed by
Certified Clinical Perfusionist
(CCP), Nurse, or M.D.**

When a Transfusion Reaction is Suspected:

1. Stop blood transfusion immediately.
2. Summon Physician to attend patient; Call the Blood Bank immediately.
3. Complete form and submit to the Blood Bank:
 - a. Properly labeled new Typenex blood specimens - one 7 ml. red top tube and one purple top EDTA tube. (Affix one new Typenex sticker to purple top.)
 - b. Properly labeled urine sample - first void after suspected reaction, when available.
 - c. Untransfused portion of blood component unit(s) with recipient set, attached IV solutions, this form, and old Typenex band stapled to form.
 - d. Old Typenex armband (removal must be witnessed by two individuals and both must sign below).
 - e. Pink copy of Confidential Medication Variance Report (NMR 0003).

PATIENT HISTORY

1. Current diagnosis: _____
2. Previous transfusion: Yes No Don't Know
3. Any pregnancies: Yes No Don't Know
4. Has patient received IV therapy or IV medications this admission. Yes No
If yes, please list: _____

CLINICAL SIGNS/SYMPTOMS (Please check if observed or reported)

- | | | |
|---|---|--|
| <input type="checkbox"/> chills | <input type="checkbox"/> increased B/P | <input type="checkbox"/> dyspnea |
| <input type="checkbox"/> headache | <input type="checkbox"/> decreased B/P | <input type="checkbox"/> cyanosis |
| <input type="checkbox"/> pain (specify) _____ | <input type="checkbox"/> fainting | <input type="checkbox"/> coughing |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> increased pulse rate | <input type="checkbox"/> oozing from wound |
| <input type="checkbox"/> hives/rash | <input type="checkbox"/> rapid temp. increase | <input type="checkbox"/> dark/bloody urine |
| <input type="checkbox"/> facial edema | <input type="checkbox"/> wheezing | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> itching | <input type="checkbox"/> frothy sputum | |

PRE AND POST TRANSFUSION VITAL SIGNS

*If available

	TIME	TEMP	B/P	PULSE	RESP	O2 SAT*	TAKEN BY
Pre-transfusion							
Post-transfusion							

TRANSFUSION DETAILS

Unit #	Date	Time	By	Unit #	Date	Time	By
Component	Started			Component	Started		
Amt Transfused	Stopped			Amt Transfused	Stopped		

PATIENT VERIFICATION - TO BE PERFORMED AT BEDSIDE BY R.N. OR M.D.

- Old Typenex band is present on patient Yes No Verified By: _____
PRINT
- Pt name and hospital number on Transfusion Report form (MR 000001) matches:
 Pt name & hospital number on Typenex armband Yes No Verified By: _____
PRINT
- Pt name & hospital number on hospital armband Yes No Verified By: _____
PRINT
- Old Typenex armband (# _____) Date/Time/Location of Band Removal: _____
 Removed By - Signature: _____ Printed Name: _____
 Witnessed By - Signature: _____ Printed Name: _____

Post-transfusion Typenex Specimen Collected By: _____ Date/Time: _____

Post-transfusion Typenex Specimen Verified By: _____ Date/Time: _____

MD/Nurse/CCP: _____ Beeper: _____ Date/Time: _____