

Affix Typenex armband here

Louisiana State University Health Care Services Division
Interim LSU Public Hospital

RECORD OF TRANSFUSION COMPLICATION
(TRANSFUSION REACTION)

This form to be completed and signed by:

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

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.) Red top labeled as per Typenex policy.
 - 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, and this completed form.
 - d. Old Typenex armband (removal must be witnessed and both individuals must sign below).
 - e. Old Typenex armband must be stapled to this form for RBC suspected reactions.
4. Document Transfusion Reaction in Quantifi (Pharmacy One Source).

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

1. Old Typenex band is present on patient: Yes No NA Verified By (Print): _____
2. Patient name, typenex number & hospital number on Transfusion Report form (LSUHSC-HCSD 505) matches:
 - a. Typenex number on Typenex armband: Yes No NA Verified By (Print): _____
 - b. Pt name & hospital number on hospital armband Yes No NA Verified By (Print): _____
3. Old Typenex armband (# _____) Date/Time/Patient Location: _____/_____/_____
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: _____

II. TRANSFUSION INFORMATION

Unit Number	Component	Date Started	Time Started	Date Stopped	Time Stopped	Amount Infused	By

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

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

IV. PRE AND POST TRANSFUSION VITAL SIGNS

*If available

TRANSFUSION INFO	TIME	TEMP	BP	PULSE	RESP	O2 SAT*	TAKEN BY
Pre-transfusion							
Post-transfusion							

V. PATIENT HISTORY

1. Current diagnosis: _____
2. Previous transfusion? Yes No Unknown
3. Transfused within the previous 24 hours? Yes No Unknown
4. Fever within the previous 24 hours? Yes No Unknown
5. Any pregnancies? Yes No Unknown
6. Has patient received IV therapy or IV medications this admission? Yes No If yes, please list: _____