In the event of a Suspected Transfusion Reaction:
Please complete and return to your nearest Blood Bank ASAP.

WP Blood Transfusion Service
Do something remarkable

a) Patient Particulars

Patient's Surname																	
First Name																	
Hospital Number												Title:	Mr	Mrs	Ms	Baby	
Date of Birth	D	D	M	M	Y	Y	Y	Y	Hosp			Ward					

b) Transfusion Particulars

Transfusion commenced at (date & time) _____ Reaction observed at (date & time) _____

Serial number(s) of suspect unit(s) _____ Expiry date of product(s) _____

Blood product administered _____ Volume administered before adverse reaction _____

Primary diagnosis: _____ Is patient currently infected (circle)? Yes / No If Yes, with which infection_____

Indication for transfusion_____Transfusion history (if available) _____

Death occurred at (date & time) _____ Death certificate completed (Yes/No) _____

Probable cause of death and contributing factors _____

Reaction reported verbally to Blood Bank at (date & time) _____by _____ Post-transfusion samples, used and unused units, containers of IV additives used plus giving sets returned to the Blood Bank at (date & time) _____by_____

c) Diagnosis & Clinical Status before transfusion (Clearly mark with Yes or No)

Previous adverse reactions			
Haemolytic Disease			
Previous pregnancies			
Raised Bilirubin			
Intravenous medications			
Bleeding			
Blood warmed			
Coagulopathy			
Massive transfusion given			
Renal disease			
DIC			
Record baseline observations	BP:	Pulse:	Temp:

d) Signs of Adverse Reaction (Clearly mark those observed with an X)

Rigors/Chills		
Sweating		
Facial Flushing		
Urticaria		
Bronchospasm		
Deep breathing		
Tachycardia		
Vomiting		
Haematuria		
Jaundice		
Abnormal bleeding		
Renal shut down		
Flank pain		
Record temperature increase		From: ..... °C to ..... °C
Hypotension		Record BP reading:
Hypertension		Record BP reading:

This form must accompany:

1. All used and unused units
2. All giving sets and IV solutions
3. Post transfusion blood samples – 2 EDTA tubes

Action to be taken by staff treating the patient:

1. Stop transfusion.
2. Notify physician immediately.

Please complete crossmatch laboratory request form if further units are required.

Clinician Particulars

Name of Doctor In Charge (Please print) _____Signature _____

Contactable telephone numbers _____Date _____

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