REPORT OF TRANSFUSION COMPLICATION

This Form is to be completed by Nurse or M.D.

WHEN A TRANSFUSION REACTION IS SUSPECTED:

1. Stop blood transfusion immediately.
2. Immediately notify attending physician.
3. Complete this form and submit to LifeShare Blood Center Laboratory with the following:
   a. Properly labeled blood samples - one 7 mL red top tube and one 7 mL purple top (EDTA) tube.
   b. Blood product container with all attached tubing and infusion fluids (if available).

Patient Name: _____

ID Number: _____

Doctor: _____

Facility Name: _____

Facility Location: _____

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 I.V. therapy or I.V. medications within the last 3 days?_____
   If Yes, please list: _____
   _____

CLINICAL SYMPTOMS (Please check all that apply):

☐ Chills	☐ Hives	☐ Dyspnea
☐ Headache	☐ Itching	☐ Cyanosis
☐ Chest pain	☐ Rash	☐ Coughing
☐ Back pain	☐ Decreased B/P	☐ Oozing from wound
☐ Frothy sputum	☐ Increased pulse rate	☐ Immediate post-transfusion jaundice
☐ Nausea	☐ Temperature increase (1ºC or 2ºF)	☐ Acute respiratory distress/pulmonary edema
☐ Vomiting	☐ Facial edema	☐ Other_____

PRE AND POST TRANSFUSION VITAL SIGNS:

	Date/Time	Temperature	Blood Pressure	Pulse	Respiration
Pre-transfusion					
Post Transfusion					

TRANSFUSION DETAILS:

Unit #: _____ Component: _____ Volume Infused: _____ mL

Start Date/Time: _____ Stop Date/Time: _____

Other transfusions within last 24 hours (list unit number and product type): _____

Blood Samples Collected By: _____ Date: _____

Form Completed By: _____ Date: _____