



## Report of Transfusion Complications

**This form is to be completed by a nurse or an MD**

### When a transfusion reaction is suspected:

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

**Facility name:** \_\_\_\_\_ **Facility location:** \_\_\_\_\_

**Patient name:** \_\_\_\_\_

**ID number:** \_\_\_\_\_ **Doctor:** \_\_\_\_\_

### Patient History

1. Current diagnosis: \_\_\_\_\_
2. Previous transfusion:  Yes  No  Unknown
3. Any pregnancies:  Yes  No  Unknown
4. Has the patient received IV therapy or IV medications within the last 3 days? \_\_\_\_\_  
If Yes, please list: \_\_\_\_\_

### Clinical symptoms (please check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chills        | <input type="checkbox"/> Hives                               | <input type="checkbox"/> Dyspnea                                    |
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Itching                             | <input type="checkbox"/> Cyanosis                                   |
| <input type="checkbox"/> Chest pain    | <input type="checkbox"/> Rash                                | <input type="checkbox"/> Coughing                                   |
| <input type="checkbox"/> Back pain     | <input type="checkbox"/> Decreased BP                        | <input type="checkbox"/> Oozing from wound                          |
| <input type="checkbox"/> Frothy sputum | <input type="checkbox"/> Increased pulse rate                | <input type="checkbox"/> Immediate post-transfusion jaundice        |
| <input type="checkbox"/> Nausea        | <input type="checkbox"/> Temperature increase (1 °C or 2 °F) | <input type="checkbox"/> Acute respiratory distress/pulmonary edema |
| <input type="checkbox"/> Vomiting      | <input type="checkbox"/> Facial edema                        | <input type="checkbox"/> 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 the last 24 hours (list unit number and product type): \_\_\_\_\_

Blood samples collected by: \_\_\_\_\_ Date: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_