Department of Transfusion Medicine
AIIMS Jodhpur

Patient's sticker

REPORT OF SUSPECTED TRANSFUSION REACTION

STOP THE TRANSFUSION AND VERIFY INFORMATION BELOW

INFUSION RECORD (Please tick mark the appropriate option)

☐ Yes ☐ No The identity of the patient agrees with the Name and CR no. of the patient.
☐ Yes ☐ No The Name and CR no. on the Blood Centre Compatibility label agrees with those of the patient.
☐ Yes ☐ No The ABO and Rh type on the Blood Centre Compatibility label agrees with those on the component label.
☐ Yes ☐ No The Unit Number on the attached Compatibility label agrees with the Unit Number on the component label.

Clinical diagnosis: _____ Indication for Transfusion _____

- Previous H/O Transfusion(s) ☐ YES ☐ NO If YES, Give details _____ and Last transfusion date_____
- H/O Previous Transfusion Reactions: ☐ YES ☐ NO. If YES, give details _____
- Equipment used: ☐ Blood infusion set / ☐ Blood warmer ☐ Reinfusion device ☐ Pressure device ☐ Pump / Bed side filter
- Was Patient under anesthesia at time of transfusion? ☐ YES ☐ NO
- Was patient pretreated for transfusion? ☐ YES ☐ NO If YES, Pretreatment Medications_____ Time: _____

SYMPTOMS OF THE SUSPECTED REACTION:

Patient Data				
Vital Signs	**Pre-Transfusion**	**During Reaction**	**Post-Transfusion**	**Check all that apply:**
Time				☐ Chills ☐ Rigors ☐ Fever (1°C or 2°F rise in temperature) ☐ Flushing ☐ Urticaria ☐ Wheeze ☐ Stridor ☐ Cough ☐ Dyspnea ☐ Chest Pain ☐ Raised JVP ☐ Shock ☐ Back Pain ☐ Heat / Pain at the IV site ☐ Bleeding ☐ Hemoglobinuria ☐ Oliguria ☐ Jaundice ☐ Anxiety ☐ Nausea ☐ Vomiting ☐ Other: _____
Temperature				
Blood Pressure				
Pulse				
Respiratory Rate				
O_2 Sat.	sPo2: ☐ Room Air ☐ O_2 Therapy _____ L/min	sPo2: ☐ Room Air ☐ O_2 Therapy _____ L/min	sPo2: ☐ Room Air ☐ O_2 Therapy _____ L/min	

GIVE A BRIEF DESCRIPTION OF THE REACTION:

DONOR BLOOD SUSPECTED OF CAUSING REACTIONS

UNIT NO._____COMPONENT: _____ VOLUME TRANSFUSED: _____

Date and time of issue from blood centre	
Date and time of start of transfusion	
Date and time of reaction	
Date and time of recovery	

MEASURES TAKEN:

☐Transfusion temporarily stopped ☐ Analgesics ☐ Diuretics ☐ Antipyretics ☐ Steroids ☐ Antibiotics ☐ Supplementary O2
☐ Antihistamines ☐ Blood culture sent ☐ Mechanical ventilation ☐ ICU required ☐ Chest X-ray ☐ Vasopressors ☐ABG/VBG ☐Urine R/M
☐ Others (Please specify) _____

SEND THE FOLLOWING TO THE BLOOD CENTRE FOR ALL SUSPECTED TRANSFUSION REACTIONS (Please tick mark):

a. ☐ 5 mL blood specimen each in an EDTA (DARK LAVENDER TOP) tube and in CLOT ACTIVATOR (YELLOW TOP) tube labelled with:
   - Patient Sticker, Phlebotomist Signature, Date & time of sampling and the note "POST REACTION"

b. ☐ The blood component under investigation with attached IV set.
c. ☐ Urine sample labelled with patient sticker, Date & time of sampling and the note "POST REACTION".
d. ☐ A COPY OF THIS COMPLETED FORM. PLACE THE ORIGINAL IN THE PATIENT'S MEDICAL RECORD.

Date:

Name of Nursing officer:
Sign:

Name of Resident Doctor/ Faculty
Sign:
Contact No:

Please Contact the Blood Bank at ext. 1436 For Questions or Assistance

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SUSPECTED TRANSFUSION REACTION-BLOOD CENTRE REPORT (*To be filled by blood centre only*)

Patient's Name: _____**Age/Gender:** _____ **CR no.:** _____

Ward: _____ **Consultant:** _____ **Resident:** _____

Date of receiving transfusion reaction form _____

Patient's Pretransfusion Records:

ABO & Rh:_____Crossmatch: _____ Crossmatch Date: _____ Crossmatch done by:_____

Date Issued:_____ Time Issued: _____

Returned Component Record: BLOOD BAG

Component type_____Amount Returned_____Expiration Date _____Compatibility Label on Product: □ Yes □ No

ABO & Rh: _____ Donor unit no.:_____ Appearance: _____

Manufacturer of bag:_____ Lot no.:_____ Expiry of bag:_____ Segment no.:_____

Check blood product for bacterial contamination (i.e., peculiar odor, brownish or purple color, clots, or abnormal masses in bag) □ Yes / □ No _____

Blood product bag sent for culture if contamination is suspected or if any of the following clinical indicators are present:

- □ shock
- □ hypertensive (systolic rises ≥ 30mm Hg)
- □ hypotensive (systolic falls ≥ 30mm Hg)
- □ fever (2ºC or 3.5ºF rise in temperature)
- □ rigors (shaking chills)
- □ tachycardia (heart rate is ≥ 120/min, or rises ≥ 40/min above pre-transfusion rate).

COMPATIBILITY LABEL

Patient ABO & Rh_____ Unit ABO & Rh_____ Unit no. _____

Patient Name:_____ _CR no.: _____

Patient's Specimen

	Visual Hemolysis Check (Pos/Neg)	anti -A	anti-B	anti-AB	anti-D	A_1c	Bc	Oc	Auto -ctrl	Blood group	DAT	IAT	Ab screen	Crossmatch		
														Saline	37^0C	AHG
PRE																
POST																

Other Results/Comments:

Laboratory investigations

	Hb/ Hct	Total WBC	Platelet count	Peripheral smear report (Any fragmented cells/ spherocytes/ RBC agglutination)	LDH	LFT			Urine microscopy/ Hb	Any other lab. finding/ Comments
						TB/ IB	Total protein/ albumin	ALT/ AST		
PRE										
POST										

Unit Culture results: _____Unit Gram stain results if indicated: _____Patient culture results_____

Impression:

Imputability:

Advice:

TRANSFUSION MEDICINE RESIDENT NAME & SIGNATURE: _____ **Date:** _____

TRANSFUSION MEDICINE FACULTY NAME & SIGNATURE: _____ **Date:** _____

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