ST. JOSEPH'S Hospital Health Center

Please Place Patient Label Here
DO NOT COVER BARCODE

15329

301 Prospect Ave, Syracuse, NY 13203

ADVERSE REACTION TO BLOOD/ BLOOD PRODUCTS REPORT (use black ink only)

ANY REACTION TO BLOOD/BLOOD PRODUCTS MUST BE REPORTED TO THE BLOOD BANK IMMEDIATELY

UNIT INFO

Donor unit number(s) associated with reaction: Patient Location:

BLOOD PRODUCT: (Specify red cells, platelets, plasma) DIAGNOSIS:

Date/Time of transfusion: Was medication inadvertently added to blood product: ☐ No ☐ Yes, Specify:

Entire unit was given: ☐ Yes ☐ No Volume transfused:

CLINICAL SERVICES TO COMPLETE

PRE-TRANSFUSION VS				VS AT REACTION TIME				POST-REACTION VS			
Time:	Temp:	BP:	Pulse:	Time:	Temp:	BP:	Pulse:	Time:	Temp:	BP:	Pulse:

CHECK ALL THOSE THAT APPLY:

☐ Hives (Urticaria) ☐ Shock ☐ Pain (Location:_____) ☐ Decreased Urine Output ☐ Anaphylaxis
☐ Itching ☐ Muscle Aching ☐ Failure to clot ☐ Petechiae ☐ Dyspnea
☐ Chills ☐ Jaundice ☐ Dark or Red Urine ☐ Hypotension
☐ Elevated temp 1.8°F or greater ☐ Other: _____

FOR ALL REACTIONS: (Initial line to indicate actions taken.)

_____ Stopped transfusion Date: _____Time: _____
_____ Patient identification checked: compared Blood Bag tag, patient arm band and physician order
_____ Accurate _____ Inaccurate, Specify: _____
_____ Notified Blood Bank of reaction Date:_____Time: _____ Person notified: _____
_____ Notified Physician/designee Date:_____Time: _____ MD notified: _____
_____ Sent pink top tube to Blood Bank if indicated.
_____ Sent remainder of unit to Blood Bank if indicated.
_____ Attached a copy of the Transfusion Administration Record to this form and sent to Blood Bank.
_____ Has patient had previous transfusion complications? ☐ Yes ☐ No ☐ Unsure
_____ Antihistamines, antipyretics or steroids given prior to transfusion? ☐ No ☐ Yes ☐ Specify: _____
Signature: _____ R.N. Time:_____

LABORATORY INVESTIGATION ♦ CHECK IF NOT INDICATED (i.e: Allergic, Hives, Itching) ☐

FOR LAB USE ONLY

Check all specimens and unit bag for proper identification. ☐ Accurate ☐ Inaccurate
Previous history of transfusion reactions: ☐ No ☐ Unit has not been returned, computer check only.
☐ Yes Culture performed on blood product:
☐ No ☐ **Yes (Report to follow)**

	PRE	POST
Plasma Appearance		
DAT on sample		
ABO/Rh on sample		

ACC # _____
DAT called to _____ at _____
by _____.

☐ Transfusion resumed following negative workup per _____M.D.
****Transfusions with febrile reactions greater than 3.5 degrees F cannot be resumed.**

TECHNICIAN SIGNATURE: _____Date: _____Time:_____

CONCLUSION/RECOMMENDATIONS: Is there evidence of incompatibility? ☐ Yes ☐ No
☐ Allergic Reaction ☐ Febrile Nonhemolytic Reaction ☐ Hemolytic Reaction ☐ Other: _____

SIGNATURE OF PATHOLOGIST: _____ Date:_____Time:_____

CPT Code 86078