UPSTATE UNIVERSITY HOSPITAL AT COMMUNITY GENERAL

ADVERSE REACTION TO BLOOD / BLOOD PRODUCTS REPORT

PATIENT LABEL

ANY REACTION TO BLOOD/BLOOD PRODUCTS <u>MUST BE</u> REPORTED TO THE BLOOD BANK IMMEDIATELY.

UNIT INFO

DONOR unit number 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 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) ☐ Itching ☐ Chills ☐ Elevated temp 2°F or greater
☐ Shock ☐ Muscle Aching ☐ Jaundice
☐ Pain (Location: _____) ☐ Failure to clot ☐ Dark or Red Urine ☐ Other: _____
☐ Decreased Urine Output ☐ Petechiae ☐ Hypotension
☐ Anaphylaxis ☐ Dyspnea

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

TRANSFUSION MAY NOT BE RESTARTED IF TEMP INCREASES 2.0°F OR GREATER.

____ Stopped transfusion. Date: _____ Time:_____
____ Patient identification checked: compare 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: _____
____ Attached a copy of the Transfusion Administration Record to this form (form 45207).
____ Sent pink top tube to Blood Bank if indicated (exception: allergic reactions and all reactions to plasma or platelets).
____ Sent remainder of unit to Blood Bank (with attached tubing) if not restarting unit.
____ Has patient had previous transfusion complications? ☐ Yes ☐ No ☐ Unsure
____ Antihistamines, antipyretics or steroids given given prior to transfusion? ☐ No ☐ Yes, Specify: _____

Signature: _____ R.N. Time:_____

LABORATORY INVESTIGATION ♦ CHECK IF NOT INDICATED (ie: Allergic, Hives, Itching) ☐

FOR LAB USE ONLY

Check all specimens and unit bag for proper identification. ☐ Accurate ☐ Inaccurate
☐ Unit has not been returned, computer check only.

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

Culture performed on blood product : ☐ No
☐ Yes (Report to follow)

Accession # _____

Previous history of transfusion reactions: ☐ No ☐ Yes: _____
Note: If hemolysis is present in the post-transfusion sample, repeat venipuncture to rule out mechanical hemolysis.
DAT report called to :_____ at _____
Technician/Technologist 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