

Transfusion Reaction Report (Connect Care Downtime)

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

TSIN #	Completed by
Contact Name/number	Patient Location

Instructions - Follow AHS Transfusion of Blood Components and Products Procedure and Policy

1. Double Check Rights of Administration	2. Reaction Notifications	Date <i>(dd-Mon-yyyy)</i>	Time <i>hh:mm</i>
Patient ID matches order? <input type="checkbox"/> Yes <input type="checkbox"/> No	Time of reaction		
Patient ID matches product? <input type="checkbox"/> Yes <input type="checkbox"/> No	Lab/TM Notified		
Transfusion tag matches product? <input type="checkbox"/> Yes <input type="checkbox"/> No	MRHP Notified		
Product matches order? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:		

3. Suspected Transfusion Reaction Details

Pre-transfusion Vitals
 Temp _____ °C Pulse _____ BPM Resp _____ per min O₂ Sat _____ % BP _____ mmHg

Post-transfusion Vitals
 Temp _____ °C Pulse _____ BPM Resp _____ per min O₂ Sat _____ % BP _____ mmHg

Symptoms	Cutaneous	Inflammatory	Cardiovascular	Respiratory	GI/Urinary	Pain
	<input type="checkbox"/> bleeding <input type="checkbox"/> cyanosis <input type="checkbox"/> diaphoretic <input type="checkbox"/> erythema <input type="checkbox"/> flushing <input type="checkbox"/> jaundice <input type="checkbox"/> pallor <input type="checkbox"/> petechiae <input type="checkbox"/> pruritis <input type="checkbox"/> purpura <input type="checkbox"/> urticaria less than 2/3 of body <input type="checkbox"/> urticaria greater than 2/3 of body	<input type="checkbox"/> chills <input type="checkbox"/> rigors <input type="checkbox"/> fever <input type="checkbox"/> 38 - 39°C <input type="checkbox"/> Greater than or equal to 39°C <input type="checkbox"/> neonate <i>(greater than 37.6°C)</i>	<input type="checkbox"/> arrhythmia <input type="checkbox"/> bradycardia <input type="checkbox"/> hypotension <input type="checkbox"/> hypertension <input type="checkbox"/> shock <input type="checkbox"/> tachycardia <input type="checkbox"/> Jugular venous distension	<input type="checkbox"/> dyspnea <input type="checkbox"/> chest tightness <input type="checkbox"/> hoarseness <input type="checkbox"/> Change on O ₂ sats <input type="checkbox"/> pulmonary edema <input type="checkbox"/> rales <input type="checkbox"/> stridor <input type="checkbox"/> tachypnea <input type="checkbox"/> wheezing	<input type="checkbox"/> diarrhea <input type="checkbox"/> hemoglobinuria <input type="checkbox"/> nausea <input type="checkbox"/> oliguria <input type="checkbox"/> vomiting Other	<input type="checkbox"/> chest pain <input type="checkbox"/> flank/back <input type="checkbox"/> headache <input type="checkbox"/> infusion site heat

Intervention	X-ray/ABG performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> transfusion stopped <input type="checkbox"/> transfusion restarted <input type="checkbox"/> supplementary O ₂ <input type="checkbox"/> chest xray <input type="checkbox"/> blood culture <input type="checkbox"/> IV fluid <input type="checkbox"/> analgesics	<input type="checkbox"/> antipyretics <input type="checkbox"/> antibiotics <input type="checkbox"/> antihistamines <input type="checkbox"/> diuretics <input type="checkbox"/> vasopressors <input type="checkbox"/> steroids <input type="checkbox"/> ICU required

Service of care	<input type="checkbox"/> hematology/BMT <input type="checkbox"/> medical <input type="checkbox"/> obs/gyne	<input type="checkbox"/> oncology <input type="checkbox"/> neonate <input type="checkbox"/> surgical	<input type="checkbox"/> trauma <input type="checkbox"/> other:
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<input type="checkbox"/> Non-binary/Prefer not to disclose (X)		<input type="checkbox"/> Unknown	

3. Suspected Transfusion Reaction Details continued

 Is patient immune compromised? Yes No

 Premedication used? Yes No

List _____

IV fluids used during transfusion

List _____

ID/asset # of equipment IV Pump #: _____ Other: _____

Other comments

4. Implicated Units

Unit # / Lot #	Product Type
	<input type="checkbox"/> RBC <input type="checkbox"/> Other: <input type="checkbox"/> Platelet <input type="checkbox"/> IVIG <input type="checkbox"/> Plasma
	<input type="checkbox"/> RBC <input type="checkbox"/> Other: <input type="checkbox"/> Platelet <input type="checkbox"/> IVIG <input type="checkbox"/> Plasma
	<input type="checkbox"/> RBC <input type="checkbox"/> Other: <input type="checkbox"/> Platelet <input type="checkbox"/> IVIG <input type="checkbox"/> Plasma