INVESTIGATION OF SUSPECTED TRANSFUSION REACTION

Svc Code	WARD	BED	CLINIC	Pre Adm Testing
201-2513				☐

Pls stick label straight and within box

For LAB use only:

Lab Accn No.

Doctor

MCR NO

Clinical Diagnosis / Medication

STAT ☐

Donor No. of Last Unit given : _____

Collected Date: _____ Collected Time: _____ Collected by: _____

PRE TRANSFUSION

Temperature : _____

B/P : _____

Pulse : _____

POST TRANSFUSION

Temperature : _____

B/P : _____

Pulse : _____

PLEASE TICK OFF (✓) THOSE WHICH APPLY

☐ Tachycardia	☐ Haemoglobinuria	☐ Oliguria
☐ Hypotension	☐ Nausea	☐ Heat at I.V. Site
☐ Chills/Rigors	☐ Vomitting	☐ Pain at I.V. Site
☐ Fever	☐ Back Pain	☐ Delirium
☐ Coma	☐ Jaundice	☐ Muscle Tenderness
☐ Syncope	☐ Rash	☐ Petechiae
☐ Chest Pain	☐ Flushing	☐ Periorbital Oedema
☐ Headache	☐ Pruritus	☐ Seizure
☐ Dyspnoea	☐ Urticaria	

☐ Others (Specify)_____

LIST DONOR NO. FROM ALL SUSPECTED UNITS IN THIS TRANSFUSION SERIES

DONOR NO.	DATE	TIME		VOLUME TRANSFUSED (mL)	WHOLE BLOOD, PACKED CELLS, PLATELETS ETC
		STARTED	STOPPED		

Complete this portion of the form and return to the Blood Bank with post-transfusion reaction samples of the patient's urine and blood (EDTA or clotted).

Return the blood bags from all units in this tranfusion series.

Send the next set of specimens (blood and urine) labelled "Post Transfusion II" (only when requested by BTS).