

BLOOD TRANSFUSION REACTION REPORT

To be used for investigation of suspected reactions to fresh blood products (blood, platelets, FFP, cryoprecipitate, granulocytes)

Affix patient ID sticker here

Please complete form and forward with appropriate blood specimens and used pack to the Hospital Blood Bank: The Royal Children's Hospital (RCH) Xn 5829, The Royal Women's Hospital (RWH) Xn 2036. For advice re diagnosis, management and investigation of suspected transfusion reactions please page the on call Haematologist via switchboard (RCH dial 91, RWH dial 92).

Ward/Unit: _____	Date: _____
Clinical Diagnosis: _____	
Product being transfused: _____	Time commenced: _____
Donation (pack) number: _____	Volume transfused: _____ mL

Clerical Check (please circle)

Patient ID correct Yes / No
 Blood pack correct Yes / No
 Blood Transfusion Record correct Yes / No

Temperature in the 24 hours prior to transfusion: (Please tick)

FEBRILE AFEBRILE (<38°C)

Vital signs

	Time	Temperature	Respiration	B.P.	Pulse
Pre Reaction					
At time of Reaction					

Signs and Symptoms – Please Tick

Fever <input type="checkbox"/>	Lower Back Pain <input type="checkbox"/>	Skin Pallor <input type="checkbox"/>
Chills <input type="checkbox"/>	Chest Pain <input type="checkbox"/>	Dark Urine <input type="checkbox"/>
Nausea/Vomiting <input type="checkbox"/>	Anxiety <input type="checkbox"/>	Dyspnoea <input type="checkbox"/>
Hives/itching <input type="checkbox"/>	Headache <input type="checkbox"/>	Bleeding from wound <input type="checkbox"/>
Other (specify below) <input type="checkbox"/>		or IV site <input type="checkbox"/>

Please document any blood products given in previous 12 hours:

Donor Unit number	Product type (eg FFP)	Date	Time unit		Volume given	Reaction Yes/No
			Started	Stopped		

(Add attachment if more space required)

Reviewing doctor:

Name: _____ Tel. Ext./Page _____
(PRINT)

Signature: _____ Date: _____