SBAR- Changes to Blood Bank Forms

Situation

All blood bank forms have been converted to Adventist corporate forms. We will no longer use forms designated for each hospital site.

Background

This change was made to help standardize transfusion practice between Adventist Rehabilitation, Shady Grove Medical Center, Washington Adventist Hospital, and the future White Oak Medical Center.

Assessment

Form Name	New Corporate Form Number	Retired SGMC Form Number	Retired WAH Form Number	Changes to Form Content
Downtime Blood Administration	9970-300	5200-300	520-300	Updated vital sign documentation to reflect new practice to document at start, 15 minutes, 2 hours, and stop
Request for Transfusion	9970-222	9970-222	701-222	None
Downtime Neonatal Transfusion Orders	9970-760	7030-170	703-170	No significant changes
Notice to Patients Receiving Blood Transfusion	9970-761	7400-140	460-100	No significant changes
Request for Emergency Release of Blood Products	9970-762	7030-172	703-172	1. Changed from a 3-part form to a 1-part form. This can now be accessed from Forms on Demand and will no longer need to be ordered. 2. Deleted the area for emergency area personnel to complete.
Transfusion Orders	9970-763	7030-171	703-171	Updated transfusion indications for red cells to match updated indications in Cerner

Recommendation

Please discard old forms and replace with copies of the new forms. All new forms can be accessed through Forms on Demand with one exception. The 2-part "Request for Transfusion" form must be ordered from Taylor Communications (previously Standard Registry).

Contact Stephanie Codina at SGMC x6689 or WAH x6015 with questions.

Place patient/unit label here or complete the following:

Patient Information

Name
Medical record number
Blood bank number
Date of birth
ABO/Rh
Crossmatch Results ☐Compatible ☐N/A ☐Least Incompatible

Unit Information

Donor ID	Expiration date/time	ABO/Rh	Attributes
Date/Time of issue:	Issued to:	Visual inspection: ☐Acceptable ☐Not acceptable	

We certify that before starting the blood transfusion, we have checked the following:

☐ 1. Verify the provider order for transfusion.
☐ 2. Verify the consent for transfusion.
☐ 3. Compare the patient's last and first name and medical record number on the blood bank and hospital armbands. Ensure they match exactly.
☐ 4. Compare the patient's last and first name and medical record number on the hospital armband and patient/unit label. Ensure they match exactly.
☐ 5. Compare the blood bank number on the patient's blood bank armband and the patient/unit label. Ensure the number matches exactly.
☐ 6. Compare the donor identification number (unit number) on the blood product label and the patient/unit label. Ensure the number matches exactly.
☐ 7. Compare the expiration date (and time if applicable) on the blood product label and the patient/unit label. Ensure it matches exactly and has not been exceeded.
☐ 8. If the provider ordered attributes for the blood product, verify that the blood product contains the ordered attributes (CMV-negative, Irradiated, HbS-negative, HLA-matched).

Signature	Date	Time	Signature	Date	Time

Note: Contact blood bank if the transfusion will not begin immediately.

Date and Time transfusion started: _____

Date and Time transfusion completed: _____
(TRANSFUSE WITHIN 4 HOURS OF DISPENSE TIME)

Volume transfused: _____

Type of blood product:
☐ red cells
☐ plasma
☐ platelets
☐ cryoprecipitate
☐ other

Transfusion Reaction? ☐ No ☐ Yes If yes, stop transfusion, see back of sheet

	Time	B/P	HR	Resp	Temp	Initials
Pre-txn						
15 min						
2 hrs						
Txn Stop						

Reminder: Give patient "Notice to Patients Receiving Blood Transfusion" form if discharged within 12 hours of transfusion.

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DOWNTIME BLOOD ADMINISTRATION

9970-300 (12/17)

DOWNTIME BLOOD TRANSFUSION REACTION REPORT
Fax both sides of this form to blood bank.

Procedure:

1. Clamp off blood immediately; disconnect blood tubing, all extension tubing and saline. Keep vein open using new saline and transfusion tubing.
2. Check for agreement of all identifying names and numbers on patient armbands, blood product label, patient/unit label, and electronic medical record. Document below.
3. Notify attending physician immediately, or house physician if warranted to manage patient symptoms.
4. Phone Blood Bank. A phlebotomist will be sent to draw post-reaction specimen(s), if indicated.
5. Monitor vital signs every 15 min x 3, then every 30 min x 2, then hourly x 2, continue as needed. Record on frequent monitoring record and document pertinent information on nursing flowsheet.
6. Return blood container and transfusion tubing to the Blood Bank immediately. **Fax a copy of this form to Blood Bank or photocopy both sides of this form and send to Blood Bank immediately.**
7. Maintain hourly I & O until further orders are obtained.

Clerical Check

☐ 1. Compare the patient's last and first name and medical record number on the blood bank and hospital armbands. Ensure they match exactly.
☐ 2. Compare the patient's last and first name and medical record number on the hospital armband and patient/unit label. Ensure they match exactly.
☐ 3. Compare the blood bank number on the patient's blood bank armband and the patient/unit label. Ensure the number matches exactly.
☐ 4. Compare the donor identification number (unit number) on the blood product label and the patient/unit label. Ensure the number matches exactly.
☐ 5. Compare the expiration date (and time if applicable) on the blood product label and the patient/unit label. Ensure it matches exactly and has not been exceeded.
☐ 6. If the provider ordered attributes for the blood product, verify that the blood product contains the ordered attributes (CMV-negative, Irradiated, HbS-negative, HLA-matched).

Clinical Diagnosis prior to transfusion:_____

History of pregnancy or abortion?_____ When?_____

History of previous transfusions?_____ When?_____

History of previous reactions?_____ When?_____

Medications at the time of transfusion (list)_____

_____

Time Reaction First Noted_____ AM PM Time Blood Discontinued_____ AM PM

Volume Transfused (approx.) _____mL

PLEASE CHECK THOSE THAT APPLY

☐ ↑ Pulse	☐ Syncope	☐ Nausea	☐ Flushing	☐ Delirium
☐ ↓ B/P	☐ Chest Pain	☐ Vomiting	☐ Pruritus	☐ Muscle Tenderness
☐ Chills	☐ Headache	☐ Back Pain	☐ Hives	
☐ Fever	☐ Dyspnea	☐ Jaundice	☐ ↑ Urine Output	☐ Petechiae
☐ Coma	☐ Hemoglobinuria	☐ Rash	☐ Heat/Pain at IV Site	☐ Bleeding

☐ Other comments (Specific)_____

_____

Signature:_____ Signature:_____

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DOWNTIME BLOOD ADMINISTRATION

9970-300 (12/17)

Fax Completed Form to Blood Bank.

Red Blood Cells: **(leukocyte-reduced, irradiated, CMV-negative, HbS-negative)** _____ mLs Pre-transfusion Hct _____ Date _____	___ Hct less than 20% ___ Hct less than 30% with symptom or risk (check below) ___ Hct less than 35% and on >35% O_2 hood ___ Hct <35% and on CPAP ___ Hct <35% with ventilation (mean pressure >6-8 mm of H_20) ___ Hct <45% with congenital cyanotic heart disease **Symptoms or Risks:** ___ Tachycardia (HR>180 beats/min for 24 hours) ___ Tachypnea (RR >80 beats/min for 24 hours) ___ Apnea (>6 episodes in 12 hours) ___ Bradycardia (2 occasions/24 hours requiring ventilation and medication) ___ Low weight gain (<10 g/day over 4 days) ___ >35% O_2 requirement ___ On high flow nasal cannula (> 2 L/min) ___ On CPAP
Platelets: **(leukocyte-reduced, irradiated, CMV-negative)** _____ mLs Pre-transfusion Plt Count _____ Date _____	___ Platelet count <30,000 ___ Platelet count <50,000 with active bleeding ___ Platelet count of <50,000 with risk of bleeding ___ Platelet count <75,000 in a micropreemie <7 days old ___ Platelet count <100,000 with invasive procedure ___ Platelet dysfunction with active bleeding ___ Platelet dysfunction with invasive procedure
Plasma: _____ mLs Pre-transfusion INR _____ PTT _____ Date _____	___ Active bleeding with coagulopathy ___ Invasive procedure with coagulopathy ___ Replacement of factor V
Whole Blood (Reconstituted): **(leukocyte-reduced, irradiated, CMV-negative, HbS-negative)** _____ mLs Requires 2 hours to prepare	___ Neonatal exchange transfusion

☐ Telephone order from _____ MD / NP / PA (circle one) _____ Date _____ Time _____ ☐ **RB&C**

Provider Signature _____ ID# _____ Date _____ Time _____

Nurse Signature _____ Date _____ Time _____

USC Signature _____ Date _____ Time _____

ONE FORM IS REQUIRED FOR EACH PRODUCT TO BE PREPARED

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DOWNTIME NEONATAL TRANSFUSION ORDER FORM

9970-760 (12/17)

Notice to Patients Receiving Blood Transfusions

Occasionally, some people will have a reaction to transfused blood products. The reaction will usually be noticed immediately after (or even during) the transfusion, but can be delayed as long as 72 hours. Contact your physician immediately if you notice any of the following symptoms after transfusion.

- Rapid heart rate
- Chills
- Fever (increased temperature)
- Chest pain
- Headache
- Trouble breathing
- Decreased urine output
- Muscle tenderness
- Fainting
- Blood in urine
- Nausea/vomiting
- Back pain
- Yellow skin
- Rash
- Hives/itching
- Heat/pain at IV site
- Bleeding

LIP's name_____ LIP's number_____

Nurse's signature_____ Date_____ Time_____

Patient Acknowledgement_____

Make a copy of the form after signatures are obtained

Original is given to patient and copy is retained in patient's medical record

PHYSICIAN: READ AND SIGN THE FOLLOWING

I have requested the release of blood for the patient indicated below without the completion of all requirements of the routine pretransfusion tests.

In my best judgement, immediate transfusion is needed, and any delay caused by completion of pretransfusion testing may be detrimental to this patient.

Reason for Transfusion: _____

Request (list quantity): _____ RBCs _____Plasma _____Platelets _____Cryoprecipitate

I assume full responsibility for any transfusion reaction the patient may incur as a result of any incomplete tests.

SIGNATURE OF REQUESTING PHYSICIAN/LIP: _____ _____
Date/Time

BLOOD BANK PERSONNEL COMPLETE THE FOLLOWING

Patient ABO/Rh: _____ ☐ Patient ABO/Rh Unknown: Blood Bank Arm Band No.: _____

Pretransfusion tests not completed (please check):
☐ ABO/Rh ☐ Crossmatch ☐ Provider Acknowledgment of Least Incompatible Red Cells
☐ Antibody Screen ☐ Antibody ID ☐ Other: (List) _____

Unit Number/DIN	ABO/Rh of Unit	Expiration Date of Unit	Blood Product Type (Circle)	Appearance Acceptable? Y or N	Transfused? Y or N	Returned to Blood Bank Date and Time
			RBC Plasma Platelet Cryo			
			RBC Plasma Platelet Cryo			
			RBC Plasma Platelet Cryo			
			RBC Plasma Platelet Cryo			
			RBC Plasma Platelet Cryo			
			RBC Plasma Platelet Cryo			

ISSUED TO: _____ ISSUED BY: _____ DATE ISSUED: _____ TIME ISSUED: _____

Y = Yes **N** = No

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REQUEST FOR EMERGENCY RELEASE OF BLOOD PRODUCTS

9970-762 (12/17)

Fax completed form to blood bank

PHYSICIAN ORDERS	Indications for Transfusion: (Must be completed)
Red Blood Cells _____ units Pre-transfusion Hb _____ Date _____ ☐ Patient has sickle cell disease (not trait)	_____ Hb < 7 _____ Hb > 7 and < 9 with symptoms* or risk** (indicate below) _____ Active bleeding _____ Peri-operative with anticipated blood loss > 500 cc _____ Hb > 9 in the absence of active bleeding (indicate reason) Reason for transfusion: _____ ***Note: any transfusion w/ hb >9 in the absence of active bleeding will automatically be referred to peer review.*** **Signs or Symptoms** _____ Postural hypotension _____ Tachycardia _____ Transient ischemic attack _____ Altered mental status _____ Signs of shock _____ Dyspnea _____ Syncope _____ Angina **Increased risk** _____ Myocardial ischemia/CAD _____ Hemoglobinopathy _____ Valvular heart disease _____ Respiratory failure _____ Congenital heart disease _____ CHF _____ COPD _____ Sepsis _____ Cerebral ischemia/TIA/Stroke
Apheresis Platelets Maximum of 2 per order **(1 unit = 1 adult dose)** _____ units Pre- transfusion Plt. Count _____ Date _____	_____ Plt ct < 15, 000/μL with or without active bleeding _____ Plt ct < 50, 000/μL with active bleeding _____ Plt ct < 100,000/μL in patient undergoing invasive procedure or massive transfusion _____ Evidence of platelet dysfunction with: _____ active bleeding or _____ pre-op _____ Massive Transfusion (> 10 units pRBCs/24 hours or > 30cc/kg loss) _____ Acute hemorrhage with > 3 liters volume replacement or > 40cc/kg loss _____ S/P open heart surgery or acute dialysis _____ In the absence of any of the above indications following consultation with the pathologist. Contacted Dr._____ on_____(date) at _____ (time)
Plasma Maximum of 2 per order _____ units Pre-Transfusion INR _____ PTT _____ Date _____ _____mL for plasma apheresis procedure	_____ Active bleeding with coagulopathy (INR >1.7 or PTT > 55 sec) _____ Undergoing invasive procedure with coagulopathy (INR > 1.5 or PTT > 55 sec) _____ Replacement of factor V due to factor V deficiency _____ Thrombotic thrombocytopenic purpura (TTP) _____ Therapeutic apheresis procedure _____ Acute hemorrhage with > 3L or > 40 cc/Kg volume replacement _____ Hereditary angioedema _____ In the absence of any of the above indications following consultation with the pathologist. Contacted Dr._____ on_____(date) at _____ (time)
Cryoprecipitate _____ units (1 adult dose = 10 units) Pre-transfusion fibrinogen _____	_____ Hypofibrinogenemia or dysfibrinogenemia _____ Massive Transfusion

Special Transfusion Attributes (CMV, Irradiated, HLA-matched, etc.)
Attribute(s) Requested: _____
Indication: _____

ICD-10 Diagnosis to Support Transfusion	Transfusion Rate:
Required for Outpatients	_____ Normal Rate: 165-180 mL/hour _____ Slow Rate: 75-95 mL/hour (for patients who are frail, on Lasix, or at risk of volume overload) _____ Fast Rate: As fast as the patient can tolerate

☐ Telephone order from _____ MD / NP / PA (circle one) _____ Date _____ Time _____ ☐ **RB&C**

Provider Signature _____ ID# _____ Date _____ Time _____

Nurse Signature _____ Date _____ Time _____ USC Signature _____ Date _____ Time _____

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DOWNTIME TRANSFUSION ORDERS

9970-763 (12/17)