TRANSFUSION REACTION WORKUP FORM

☒ St. Joseph Medical Center Tacoma, WA ☐ St. Clare Hospital Lakewood, WA ☐ St. Elizabeth Hospital Enumclaw, WA
☐ St. Francis Hospital Federal Way, WA ☐ St. Anthony Hospital Gig Harbor, WA ☐ PSC

INITIAL INVESTIGATION:

- Record Cerner patient and unit information in the first column. Then perform clerical check. Circle Y or N to indicate if item in header matched information present in the first column.

Place patient Cerner TRXN label here

Cerner Patient Information	Pre-Transfusion Specimen	Post-Transfusion Specimen	Adhesive Patient Label	Unit Face Label	Suspected Transfusion RXN Form	Date & Time & Tech ID
Last, First Name	Y N	Y N	Y N		Y N	
MRN	Y N	Y N	Y N		Y N	
Patient ABO/Rh			Y N			
Blood Unit #			Y N	Y N		
Unit ABO/Rh			Y N	Y N		
Blood Band #	Y N	Y N	Y N	Y N		

- List all units given during the last 12 hours. Any culture results will be attached to this document. Culture only those units involved in a patient rise in temperature of at least 1.0C (or 1.8F).

Unit(s) given in last 24 hrs.	Date/Time issued	Clerical Ck OK?	Cultured?
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N

- Order and perform a repeat ABO/Rh on the post-transfusion sample. Record below.

Post/date/time	Anti-A	Anti-B	Anti-D	A cells	B cells	Interp	Tech	Date

- Order and perform DAT on pre and post samples. Record below and result in Cerner.

Sample	Icterus? Y/N	Hemolysis? Y/N	DAT				Tech	Date
			Poly/CC/Int	IgG/CC/Int	C3d/CC/Int	Control		
Pre - transfusion			/ /	/ /	/ /			
Post – transfusion			/ /	/ /	/ /			

- Elution Performed? Y N Elution Results _____
- Transfusion Reaction Interpretation: Neg Pos (Circle one)
- Notify nurse of TRXN results: Name_____ Date/time_____

PATHOLOGIST NOTIFICATION

Pathologist must be notified when a discrepancy exists or patient condition indicates hemolysis, either of which requires an extended investigation:

Pathologist:	Date /Time	Tech
Notified: ☐ Yes ☐ No		
Name:		

EXTENDED INVESTIGATION:

Perform and record below: ABO/Rh, ABSC, XM, and other tests.

Sample	ABO/Rh						Antibody Screen				Tech	Date
	Anti-A	Anti-B	Anti-D	A cells	B cells	Interp	SI	SII	SIII	Interp		
Pre - transfusion												
Post - transfusion												

Unit Number	ABO/Rh Units					XM Pre sample		XM Post sample		Unit Ag Test ____	Tech	Date
	Anti-A	Anti-B	Anti-A,B	Anti-D	Interp	Gel IgG	Interp	Gel IgG	Interp			

Chemistry Tests as ordered by Path:	Pre Sample	Post Sample	6 HR Post Sample	Tech	Date
Bilirubin					
Other					

Post Urine Sample Date/ time collected	Color	Hemoglobin? (occult blood)	Intact RBCs?	Tech	Date
		Y N	Y N		

Comments: _____

_____

_____

Reviewed by _____ **Date** _____

RELATED DOCUMENTS

R-W-TS-0750	Transfusion Reaction – Immediate Recipient Complications
J-W-TS-0755	Transfusion Reaction – Delayed Recipient Complications
J-F-TS-1033	Culture of Blood Component Form

DOCUMENT APPROVAL **Purpose of Document / Reason for Change:**			
1. Tweaked formatting to give larger space to handwrite information 2. Included both ^{o}F and ^{o}C of temperature increase that would require culture of a unit. 3. Updated headers of some columns 4. Modified Pathologist Notification section by including checkboxes 5. Put into current document control format 6. Added Related Documents section			
☐ *No significant change to process in above revision. Per CAP, this revision does not require further Medical Director approval.*			
Committee Approval Date	☐ Date: ☒ N/A – revision of department-specific document which is used at only one facility	**Medical Director Approval** *(Electronic Signature)*	Katie Wilkinson, MD 3/19/14