Suspected Transfusion Reaction Investigation Form

**Patient Name:** **Hospital ID:**  .

**Product type:** **Unit Number(s):** *(of product(s) released)* .

**Technologist:**   **Date of Reaction:**   **Date/Time Notified:**  .

**Clerical Check:** *(Compare post transfusion sample with Transfusion Reaction Notification and Workup Request Form, Computer record, Transfusion Tag/Unit Label, Pre-sample if discrepancy noted)*

□ No Discrepancy □ Discrepancy *(describe)* .

**Product Bag:**

□ **Received** □ Tubing Attached □ IV fluids attached (type of fluid) .

 □ Bag empty OR □ Approximate residual volume ml

 □ Visual Inspection performed *(bag, residual product if applicable, tubing, IV fluids)*:

 □ Normal appearance □ Abnormal *(describe)* .

□ **Not received** *(reason)* .

**Phase 1 Testing:** *(Post transfusion patient sample),* Accession No. .

**Hemolysis Check:**  □ No hemolysis □ Hemolysis present **Microbiology:** □ **Gram Stain/ Bag Culture sent**

**ABO/Rh**

□ Not discrepant with Pre-

 Transfusion ABO/Rh

□ Discrepant with Pre-Transfusion

 ABO/Rh: .

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Anti-A** | **Anti-B** | **Anti-D** | **CT** | **A1 Cells** | **B cells** | **Interpretation** |
|   |  |  |  |  |  |  |

**DAT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **POST** | **IS** | **5 min** | **CC** | **Interpretation****Technologist Completing Testing:**  .**Date/Time:**  . |
| **POLY** |  |  |  |  |
| **IgG** |  |  |  |  |
| **C3b/C3d** |  |  |  |  |
| **Control** |  |  |  |  |

**Transfusion Medicine Physician Notification:**

**Physician Name:**  **Date/Time Contacted**  .

□ **Patient approved to receive further blood products** *(comments)*  .

□ **Additional Testing Requested** *(tests requested):* .

□ **TRALI Investigation Indicated: (circle one) YES NO To Be Determined**

**Preliminary Diagnosis**: **Additional Instructions**: .

 .

**Final Reaction Classification:** *(To be completed by Transfusion Services Physician)*

□ Acute Hemolytic □ Allergic □ Delayed Hemolytic □ Delayed Serologic □ Febrile non-Hemolytic □ Hypotensive □ Post Transfusion Purpura □ TACO □ TA Dyspnea □ TA-GVHD □ TA Infection □ TRALI □ Underlying Patient Illness/Not related to transfusion □ Unknown Pathophysiology

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Transfusion Services Attending Physician:** *(Signature)*  **Date:**

*(As requested by Transfusion Services Physician)*

**Pre-Transfusion Sample Testing:**

**Pre-transfusion Sample Hemolysis Check:**  □ No hemolysis □ Hemolysis present

**Pre-transfusion Sample ABO/Rh: Pre-transfusion Sample DAT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PRE** | **IS** | **5 min** | **CC** | **Interp** |
|  **POLY** |  |  |  |  |
| **IgG** |  |  |  |  |
| **C3b/C3d** |  |  |  |  |
| **Control** |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Anti-A** | **Anti-B** | **Anti-D** | **CT** | **A1 Cells** | **B cells** | **Interp.** |
|   |  |  |  |  |  |  |

**Unit Type Confirmation:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Anti-A** | **Anti-B** | **Anti-A,B** | **Anti-D** | **Interpretation** |
|   |  |  |  |  |
|  |  |  |  |  |

**Antibody Screen & Crossmatch:**

**Post -transfusion sample Pre-transfusion sample**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PRE** | **IS** | **37C** | **AHG** | **CC** | **Interp.** |
|  **SC 1** |  |  |  |  |  |
| **SC 2** |  |  |  |  |  |
| **SC 3** |  |  |  |  |  |
| **Unit #:** |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **POST** | **IS** | **37C** | **AHG** | **CC** | **Interp.** |
|  **SC 1** |  |  |  |  |  |
| **SC 2** |  |  |  |  |  |
| **SC 3** |  |  |  |  |  |
| **Unit #:** |  |  |  |  |  |

**Blood Cultures:**

□ Transfused Blood Product: □ Patient: .

**Other Testing:**  .

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**Transfusion Medicine Physician Notification:**

**Physician Name:**  **Date/Time Contacted:** .

□ **Additional Testing Requested** *(tests requested):* .

**Preliminary Diagnosis**: .

**Additional Instructions**: .

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□ **Patient approved to receive further blood products:** *(comments)*  .

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**Transfusion Services Attending Physician:** *(Signature)*  **Date:**