1. If you suspect a possible transfusion reaction, **STOP THE TRANSFUSION** immediately. Keep the intravenous line open (KVO) with a slow infusion of normal saline.
2. Notify the physician & Transfusion Services regarding patient management and initiate a suspected transfusion reaction (TXRN) workup.
3. If localized hives, itching, or flushing are the only manifestations of the reaction, the physician may order administration of an anti-histamine (e.g. diphenhydramine), and if symptoms/signs resolve restart the transfusion. If these reappear, stop the transfusion completely, notify Transfusion Services, and initiate a suspected TXRN workup.
4. As part of the workup, complete the “Nursing Report” section of this form.
5. Draw a pink top tube, (properly labeled with two signature verification, per policy) unless the only symptoms are hives/urticaria/itching.
6. Secure the unit and administration set. Make a copy of the attached Transfusion Record. Close tubing securely to prevent contamination. Place in plastic bag.
7. Return the patient sample, discontinued blood bag/infusion set (even if the transfusion is complete) with the copy of the Transfusion Record to the Transfusion Service with this completed form.

**Nursing Report**

**Clerical Verification**

Check the following patient and unit information in each location at the top of the column. (Circle **Y** or **N)**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient/Unit Information** | **Transfusion Record** | **Patient Armband** | **Unit Face Label** |
| **Last, First Name** | Identical? Y N | Identical? Y N |  |
| **Hospital Identification Number** | Identical? Y N | Identical? Y N |  |
| **Blood Unit Number**  **(Affix sticker here)** | Identical? Y N |  | Identical? Y N |
| **Blood Unit ABO/Rh** | Identical? Y N |  | Identical? Y N |
| **Discrepancy? (explain)** |  |  |  |

**Vital Signs and Symptoms**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date** | **Time** | **Temp** | **BP** | **Pulse** | **RR** | **PsO2** | **Vol. Transfused (ml)** |
| **Pre-Transfusion** |  |  |  |  |  |  |  |  |
| **+ 15 min** |  |  |  |  |  |  |  |  |
| **Post- Transfusion** |  |  |  |  |  |  |  |  |

**Description of Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Symptoms:**  Chills  Rigors  Dyspnea  Cyanosis  Hypertension  Hypotension

(Check all that apply)  Nausea/Vomiting  Headache  Anxiety Back/Flank Pain  Abdominal Pain

Chest pain  Pain at infusion site  Itching/Pruritis  Flushing

Hives/Urticaria: (If yes body areas)

**Other Symptoms** (describe)

**Premedication Given** (list medications, route, dose and time)

**Treatment Administered** (list medications, route, dose and time)

**Physician Notified**: Name ­­­ **Date:** **Time**: **By**: RN **Is Patient back to Baseline?**  Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| RN SIGNATURE | PRINT NAME | DATE | TIME |
| 2nd RN SIGNATURE | PRINT NAME | DATE | TIME |