BLOOD PRODUCT TRANSFUSION DOCUMENT (PRE) AUDIT STEPS

1. Transfusion cards are tubed back to IUHPL, station 946 or 947.

2. After removing cards, peel perforated edges if necessary, "face" cards correctly.

3. Place cards in appropriate "month" box. There will be 3 boxes, the month we are currently in, the month prior and another for anything else. Unfortunately, there are wards that "hold" cards. All obscure cards can go in the miscellaneous box.

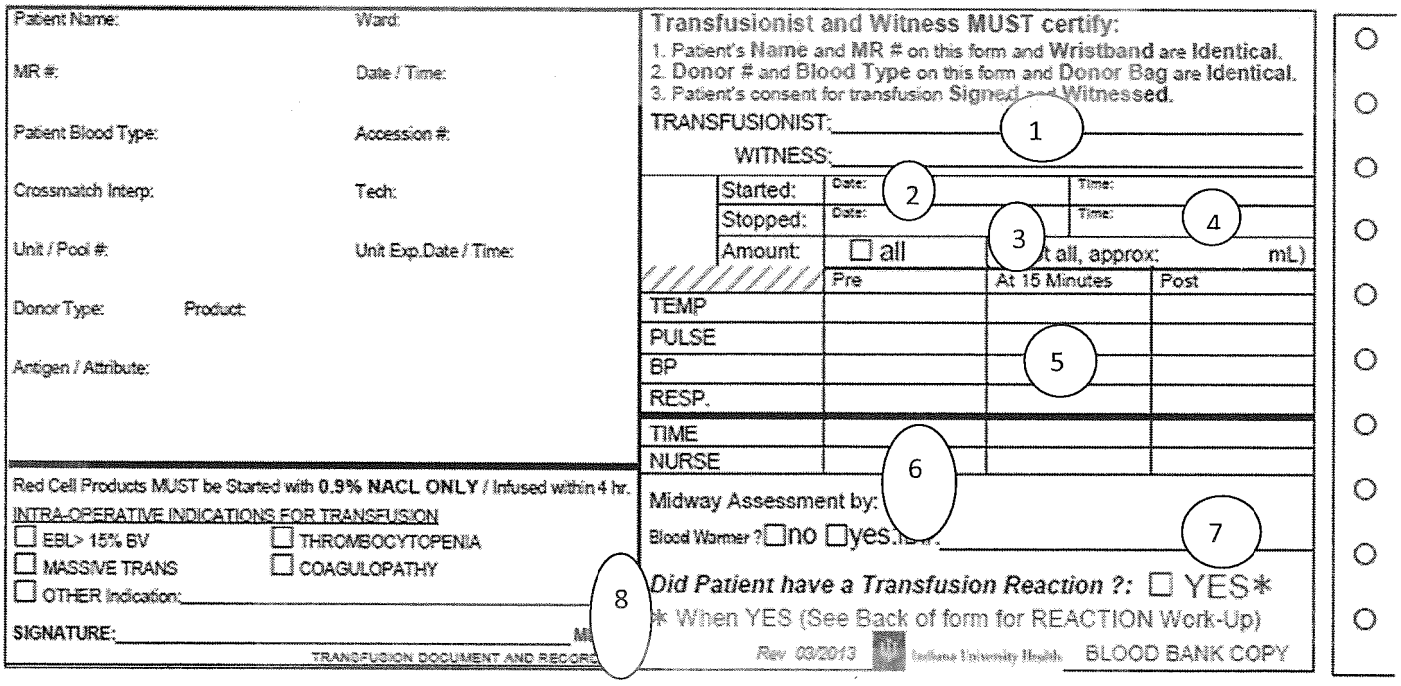
*Just glance at the month on the card and put it in the correct box. Cards do NOT NEED to be sorted by hospital.

BLOOD PRODUCT TRANSFUSION DOCUMENT AUDIT (STANDARD WARD TRANSFUSION)

The requirements are different for general transfusions vs. OR, ECMO, Massives, etc. These instructions pertain to requirements for a standard transfusion.

1. Two signatures (first initial and full last name or full name): Tranfusionist and Witness—this is necessary on ALL cards.
2. Transfusion start: date and time *Note: "pre vital" time needs to be time needs to be at least one minute earlier than "start" time

   With one exception: Apheresis cards. They usually send them 30 to 50 at a time, together. They will have a "star" in the upper right hand corner. We do NOT mark these incorrect, as the exchange products are being transfused consecutively.
3. Transfusion stop: date and time
4. Look at the start and stop time. The total time of the transfusion needs to be less than four hours.
5. Vital sign completion including: all phases. *An exception to this is the instance where a product is given in 15 minutes or less. Some nurses "slash" or "x" out the middle column and record the post vitals in the post vital box. This is actually correct. Others put the post vitals in the middle box. I don't mark these as incorrect as long as the times are entered correctly at the top end of the card.
6. Time / Nurse / Midway Assessment: Requires all times of vitals collections. These three boxes do not allow for initials. First initial and full last name or full name are required here.
7. Blood Warmer must be checked "yes" or "no". If checked "yes", an ID# must be included.
8. Documentation of a Transfusion Reaction. If checked "yes", then the back of the card must be filled out.



BLOOD PRODUCT TRANSFUSION DOCUMENT AUDIT

These cards require less documentation if section 5 contains any of the statements below.

1.) Two signatures (first initial and last name or full name): Transfusionist and Witness

2.) Transfusion start: date and time

3.) N/A

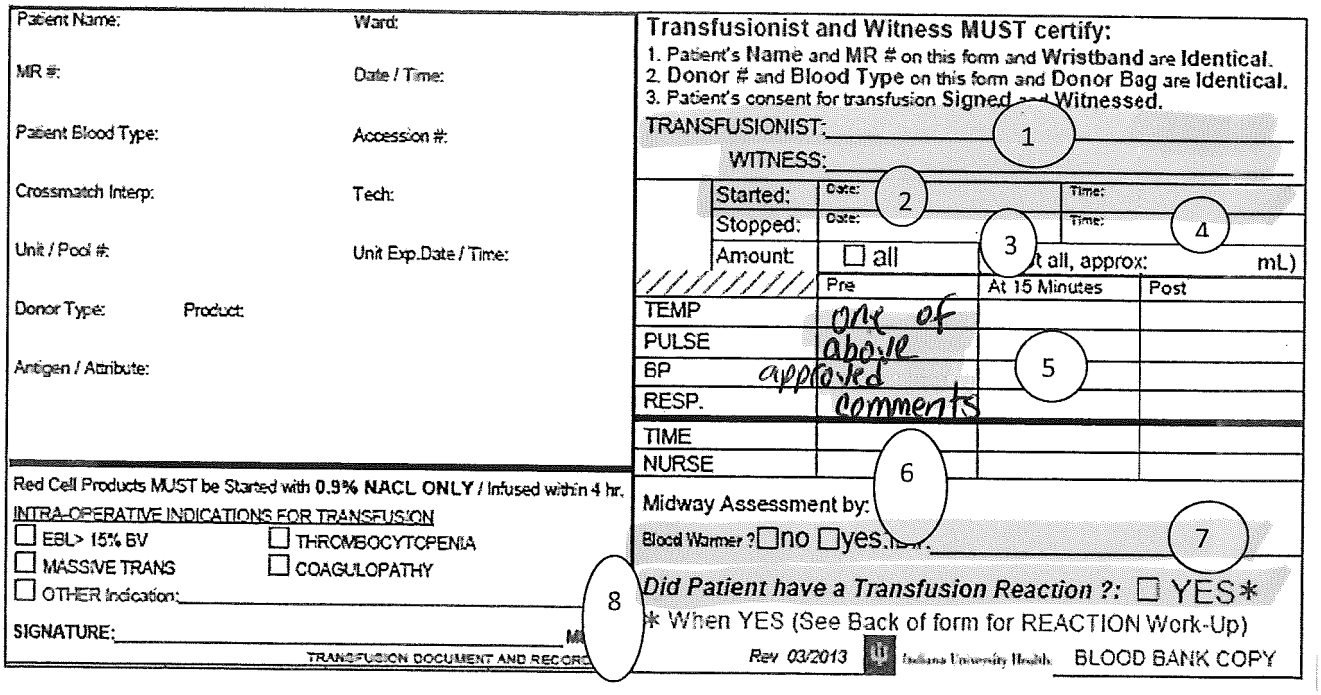
4.) N/A

5.) **Acceptable** statements in area **5: Anesthesia, SAR (see anesthesia records), Emergency, Level I, Massive, Perfusion, Pump, Rapid Infusion, "See Cerner" and Wound Patch for Cryo.**

6.) N/A

7.) Blood Warmer box needs to be checked "yes" or "no". If checked "yes" and ID number must be included.

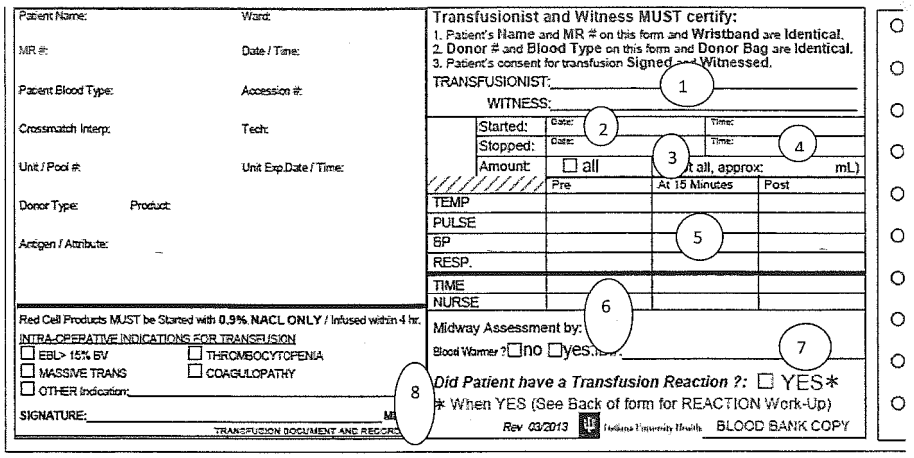
8.) Documentation of a Transfusion Reaction. If checked "yes" then the back of the card must be filled out.



AUDIT PROCESS

Count the available transfusion cards and using these guidelines audit the cards, separating correct from incorrect.

Using a PINK highlighter, highlight what was incorrect on the cards. Count how many are incorrect.



Patient Name: Ward:
MR #: Date / Time:
Patient Blood Type: Accession #:
Crossmatch Interp: Tech:
Unit / Pool #: Unit Exp.Date / Time:
Donor Type: Product:
Antigen / Attribute:

Red Cell Products MUST be Started with 0.9% NACL ONLY / Infused within 4 hr.
INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION
☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:
SIGNATURE:
TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's Name and MR # on this form and Wristband are Identical.
2. Donor # and Blood Type on this form and Donor Bag are Identical.
3. Patient's consent for transfusion Signed and Witnessed.
TRANSFUSIONIST: 1
WITNESS:

Started:	Date: 2		Time: 4
Stopped:	Date: 3		Time:
Amount:	☐ all		t all, approx: mL)
	Pre	At 15 Minutes	Post
TEMP			
PULSE		5	
BP			
RESP.			
TIME			
NURSE	6		

Midway Assessment by:
Blood Warmer ?☐no ☐yes
7
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)
8
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Date: 1 / 29 / 19

Total # of documents reviewed 100
Total # incomplete minus 20
Total # compliant equals 80

Audited By: Jimmy Page or JP → initials are fine!

Medical Director / Designee Review By:_____

Locate one of the above sheets which should be located in both the right and left side storage cabinets at the front desk on clip boards. Fill it out, then wrap it around your incorrect cards, rubber band together and place in same box at front desk that unacceptable specimens (incidents) are kept.

Finally, please separate your left over CORRECT cards **by hospital** and place in correct box. ANY Satalite/sister hospital cards will go in an envelope marked as such located in the **Riley box.**

LET'S PRACTICE!

Name:_____

Please highlight on each card what (if anything) is incorrect.

Patient Name: GREER, JILLIAN F
MRN: 72633691
Patient Blood Type: O POS
Crossmatch Interp:
Unit / Pool #: W2018 19 855046
Donor Type: A NEG
Product: E3056 APHER PLAT LR IR
Antigen / Attribute: IRRADIATED 1ST CONTAINER APHERESIS ResLeu:<5LOG6

Ward: RILEY AT IUH RT7EA
Date / Time: 01/22/2019 04:58
Accession #:
Tech: ALA
Unit Exp.Date / Time: 01/22/2019 23:59

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION
☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:_____

SIGNATURE:_____ MD

TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: Omecca Kirby, RCO
WITNESS: LuDana RN

Started:	Date: 01/22/19	Time: 0525	
Stopped:	Date: 1/22/19	Time: 0744	
Amount:	☒ all	(if not all, approx:	mL)

	Pre	At 15 Minutes	Post
TEMP	36.1	36.1	36.1
PULSE	56	49	49
BP	131/85	132/97	139/91
RESP.	12	12	12
TIME	0530	0540	0746
NURSE	LuDana RN	LuDana RN	RSJ

Midway Assessment by: LuDana RN
Blood Warmer ?☒no ☐yes:ID#:_____
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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Patient Name: Radie, Toya L
MRN: 74242985
Patient Blood Type: O POS
Crossmatch Interp: eXM Compatible
Unit / Pool #: W2016 18 797154
Donor Type: O POS
Product: E0338 RBC LR
Antigen / Attribute:

ResLeu:<5log6

Ward: University Surgery A/B
Date / Time: 01/22/2019 17:16
Accession #: 19-022-00631
Tech: TMC
Unit Exp.Date / Time: 02/13/2019 23:59

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION
☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:_____

SIGNATURE:_____ MD

TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: M. BROWN RN
WITNESS: [illegible] RN

Started:	Date: 1/22/19	Time: 1720	
Stopped:	Date:	Time:	
Amount:	☐ all	(if not all, approx:	mL)

	Pre 1729	At 15 Minutes	Post
TEMP	36.5	36.7	36.4
PULSE	119	111	109
BP	96/49	112/70	112/78
RESP.	18	12	18
TIME	1729	1745	1811
NURSE	MB	MB	MB

Midway Assessment by:_____
Blood Warmer ?☐no ☐yes:ID#:_____
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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Patient Name: Quesada, Dawson A
Ward: Riley at IUH RT5WA
MRN: 75992959
Date / Time: 01/20/2019 05:33
Patient Blood Type: A POS
Accession #:
Crossmatch Interp:
Tech: HGL
Unit / Pool #: W2018 19 855030
Unit Exp.Date / Time: 01/21/2019 23:59
Donor Type: A POS
Product: E3057 Apher PLAT LR IR
Antigen / Attribute: CMV Neg Irradiated 2nd container Apheresis ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.
INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION
☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:

SIGNATURE: MD

TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: [illegible]
WITNESS: Rachael Hawkes RN

	Date	Time
Started:	1/20/19	0657
Stopped:	1/20/19	0955
Amount:	☒ all	(if not all, approx: 196

	Pre	At 15 Minutes	Post
TEMP	37	36.9	37.0
PULSE	54	55	54
BP	87/50	100/51	111/64
RESP.	20	14	14
TIME	0656	0715	0858
NURSE	RH	CH	S.Heinzelm.

Midway Assessment by: Benjamin Jenkins RN
Blood Warmer ? ☒no ☐yes:ID#:
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

Patient Name: Burnett, Kimberly C
Ward: University U6ID U6D
MRN: 74047846
Date / Time: 01/20/2019 12:21
Patient Blood Type: O POS
Accession #:
Crossmatch Interp:
Tech: AMI
Unit / Pool #: W2018 18 910285
Unit Exp.Date / Time: 01/20/2019 16:21
Donor Type: O POS
Product: E3591 Thawed CRYOS
Antigen / Attribute:

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.
INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION
☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:

SIGNATURE: MD

TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: [illegible]
WITNESS: Rebecca Hodgkiss RN

	Date	Time
Started:	01-20-2019	1259
Stopped:	01-20-2019	1316
Amount:	☐ all	(if not all, approx: m

	Pre	At 15 Minutes	Post
TEMP	37.2	37.2	
PULSE	131	130	
BP	95/54	108/63	
RESP.	29	29	
TIME	J Towns RN	J Towns RN	
NURSE	1259	1316	

Midway Assessment by: [illegible]
Blood Warmer ? ☒no ☐yes:ID#:
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

Patient Name: Sweat, Kylee A
Ward: Riley at IUH RT5EA
MRN: 72946882
Date / Time: 01/20/2019 09:01
Patient Blood Type: A POS
Accession #:
Crossmatch Interp:
Tech: SDA
Unit / Pool #: W2018 19 855031
Unit Exp.Date / Time: 01/21/2019 23:59
Donor Type: A POS
Product: E3056 Apher PLAT LR IR
Antigen / Attribute: CMV Neg Irradiated 1st container Apheresis ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.
INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION
☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:

SIGNATURE: MD

TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: Morgan Beaty RN
WITNESS: Shelby Drennan

	Date	Time
Started:	1/20/19	1115
Stopped:	1/20/19	1330
Amount:	☒ all	(if not all, approx: 312 m

	Pre	At 15 Minutes	Post
TEMP	36.9	36.9	36.9
PULSE	64	60	74
BP	127/86	134/88	132/74
RESP.	12	20	16
TIME	1115	1130	1330
NURSE	MB	MB	MB

Midway Assessment by: Morgan Beaty
Blood Warmer ? ☒no ☐yes:ID#:
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

Ninde-mercado, Traci L | University UBNW U38

MRN: 73946342 | Date / Time: 01/23/2019 16:00

Patient Blood Type: O POS | Accession #:

Crossmatch Interp: | Tech: JRE

Unit / Pool #: W2050 18 324977 | Unit Exp.Date / Time: 01/25/2019 23:59

Donor Type: O POS | Product: E2701 Thawed PLASMA

Antigen / Attribute: Frozen <=24h

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

☒ EBL> 15% BV ☐ THROMBOCYTOPENIA

☐ MASSIVE TRANS ☐ COAGULOPATHY

☐ OTHER Indication:

SIGNATURE: MD

Transfusionist and Witness MUST certify:

1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST:

WITNESS:

		Date:	Time:
	Started:	1/23/19	1646
	Stopped:	1/23/19	1650
	Amount:	☒ all	(if not all, approx: m

	Pre	At 15 Minutes	Post
TEMP			
PULSE		SAR	
BP			
RESP.			
TIME			
NURSE			

Midway Assessment by: Anes

Blood Warmer ? ☐ no ☒ yes:ID#: 50012741

Did Patient have a Transfusion Reaction ?: ☐ YES*

* When YES (See Back of form for REACTION Work-Up)

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TRANSFUSION DOCUMENT AND RECORD

Patient Name: Chimembe, Kalunga S | Ward: Riley at IUH RT5EA

MRN: 75741205 | Date / Time: 01/20/2019 10:30

Patient Blood Type: O POS | Accession #:

Crossmatch Interp: | Tech: SDA

Unit / Pool #: W0407 18 723175 | Unit Exp.Date / Time: 01/23/2019 23:59

Donor Type: O POS | Product: E3057 Apher PLAT LR IR

Antigen / Attribute: CMV Neg Irradiated 2nd container Apheresis ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

☐ EBL> 15% BV ☐ THROMBOCYTOPENIA

☐ MASSIVE TRANS ☐ COAGULOPATHY

☐ OTHER Indication:

SIGNATURE: MD

Transfusionist and Witness MUST certify:

1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: MaryBeth Beatty

WITNESS: Shelley Dillon RN

		Date:	Time:
	Started:	1/20/19	1150
	Stopped:	1/20/19	1315
	Amount:	☒ all	(if not all, approx: 211 m

	Pre	At 15 Minutes	Post
TEMP	36.9	36.7	36.5
PULSE	109	96	92
BP	115/36	118/78	104/60
RESP.	22	22	24
TIME	1150	1205	1515
NURSE	DAB	ME	DAB

Midway Assessment by: MaryBeth Beatty

Blood Warmer ? ☒ no ☐ yes:ID#:

Did Patient have a Transfusion Reaction ?: ☐ YES*

* When YES (See Back of form for REACTION Work-Up)

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TRANSFUSION DOCUMENT AND RECORD

Patient Name: Myers, Bradley K | Ward: Methodist MA5S M5090

MRN: 72194962 | Date / Time: 01/21/2019 07:58

Patient Blood Type: A POS | Accession #: 19-021-01364

Crossmatch Interp: eXM Compatible | Tech: EBI

Unit / Pool #: W2050 18 329615 | Unit Exp.Date / Time: 02/01/2019 23:59

Donor Type: A POS | Product: E0336 RBC LR

Antigen / Attribute: ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

☐ EBL> 15% BV ☐ THROMBOCYTOPENIA

☐ MASSIVE TRANS ☐ COAGULOPATHY

☐ OTHER Indication: Hct 21 & Cond.

SIGNATURE: MD

Transfusionist and Witness MUST certify:

1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST:

WITNESS:

		Date:	Time:
	Started:	1.21.2019	1401
	Stopped:	1.21.2019	1431
	Amount:	☐ all	(if not all, approx: m

	Pre	At 15 Minutes	Post
TEMP			
PULSE		AR	
BP			
RESP.			
TIME			
NURSE			

Midway Assessment by:

Blood Warmer ? ☐ no ☐ yes:ID#:

Did Patient have a Transfusion Reaction ?: ☐ YES*

* When YES (See Back of form for REACTION Work-Up)

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Patient Name: Naggrik, Amit
Ward: University CDSU C Day
MRN: 76071097
Date / Time: 01/21/2019 14:23
Patient Blood Type: O POS
Accession #: 19-021-03317
Crossmatch Interp: eXM Compatible
Tech: JME
Unit / Pool #: W2016 18 794298
Unit Exp.Date / Time: 02/14/2019 23:59
Donor Type: O POS
Product: E0336 RBC LR
Antigen / Attribute:

ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

- ☑ EBL> 15% BV
- ☐ THROMBOCYTOPENIA
- ☐ MASSIVE TRANS
- ☐ COAGULOPATHY
- ☐ OTHER Indication:________

SIGNATURE:________ MD

TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST:________
WITNESS: M. Mull [illegible]

Started:	Date: 1/21/19	Time: 2:50	
Stopped:	Date: 1/21/19	Time: 2:58	
Amount:	☐ all	(if not all, approx:	m

	Pre	At 15 Minutes	Post
TEMP			
PULSE	See	Record	
BP			
RESP.			
TIME			
NURSE			

Midway Assessment by: Anesthesia
Blood Warmer ? ☐ no ☑ yes: ID#: 104 25578
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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Patient Name: Yee, Khin H
Ward: Methodist MEMER MWR
MRN: 76081417
Date / Time: 01/21/2019 15:05
Patient Blood Type: B POS
Accession #: 19-021-12156
Crossmatch Interp: eXM Compatible
Tech: CVO
Unit / Pool #: W2018 18 040813
Unit Exp.Date / Time: 02/14/2019 23:59
Donor Type: B POS
Product: E0336 RBC LR
Antigen / Attribute:

ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

- ☐ EBL> 15% BV
- ☐ THROMBOCYTOPENIA
- ☐ MASSIVE TRANS
- ☐ COAGULOPATHY
- ☐ OTHER Indication:________

SIGNATURE:________ MD

TRANSFUSION DOCUMENT AND RECORD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: Jody Wilson
WITNESS: [illegible] RN

Started:	Date: 1-21-19	Time: 3:20 pm	
Stopped:	Date: 1-21-19	Time: 350 pm	
Amount:	☑ all	(if not all, approx:	m

	Pre	At 15 Minutes	Post
TEMP	36.9	36.9	36.9
PULSE	63	62	60
BP	120/72	130/77	121/76
RESP.	20	20	20
TIME	315	335	355
NURSE	JW	JW	JW

Midway Assessment by: Jody Wilson RN
Blood Warmer ? ☑ no ☐ yes: ID#:________
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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Patient Name: Sweat, Kylee A
Ward: Riley at IUH RT7ER
MRN: 72946882
Date / Time: 01/23/2019 17:45
Patient Blood Type: A POS
Accession #:
Crossmatch Interp:
Tech: JRE
Unit / Pool #: W2016 18 908573
Unit Exp.Date / Time: 01/23/2019 21:45
Donor Type: A POS
Product: E3591 Thawed CRYO5
Antigen / Attribute:

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

- ☐ EBL> 15% BV
- ☐ THROMBOCYTOPENIA
- ☐ MASSIVE TRANS
- ☐ COAGULOPATHY
- ☐ OTHER Indication:________

SIGNATURE:________ MD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: Allison Durrell, RN
WITNESS: [illegible] RN

Started:	Date: 1-23-19	Time: 1810	
Stopped:	Date: 1-23-19	Time: 2000	
Amount:	☒ all	(if not all, approx:	m

	Pre	At 15 Minutes	Post
TEMP	37.1	37.2	36.9
PULSE	88	93	89
BP	114/46	111/56	114/56
RESP.	20	20	18
TIME	1808	1825	2000
NURSE	A. Durrell	A. Durrell	A. Pickett

Midway Assessment by: Ashley Pickett
Blood Warmer ? ☒ no ☐ yes: ID#:________
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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Patient Name: Anderson, Brent C
MRN: 75951819
Ward: University U4NE U442
Date / Time: 01/18/2019 06:22
Patient Blood Type: B POS
Accession #: 19-018-03356
Crossmatch Interp: eXM Compatible
Tech: KLA
Unit / Pool #: W2016 18 789986
Unit Exp.Date / Time: 01/28/2019 23:59
Donor Type: B POS
Product: E0336 RBC LR
Antigen / Attribute:

ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:

SIGNATURE: MD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: A Pichardo RN
WITNESS: Chantal Slamkowski RN

Started:	Date: 1/18/19	Time: 0701
Stopped:	Date: 1-18-19	Time: 1015
Amount:	☑ all	(if not all, approx:

	Pre	At 15 Minutes	Post
TEMP	37.0	37.1	37
PULSE	96	95	93
BP	132/74	134/70	136/78
RESP.	24	22	19
TIME	0700	0715	1016
NURSE	C Slamkowski	A Pichardo	A Pichardo

Midway Assessment by: A Pichardo RN
Blood Warmer ? ☒ no ☐ yes:ID#:
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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TRANSFUSION DOCUMENT AND RECORD

Patient Name: Muhammad, Kayin A
MRN: 74015588
Ward: MMP Eagle Highlands
Date / Time: 01/02/2019 16:10
Patient Blood Type: B POS
Accession #: 18-365-13385
Crossmatch Interp: eXM Compatible
Tech: TNG
Unit / Pool #: W2038 18 678971
Unit Exp.Date / Time: 01/24/2019 23:59
Donor Type: O NEG
Product: E0686 RBC LR
Antigen / Attribute:

C Neg E Neg K Neg Hgb S Neg
2nd container Apheresis ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:

SIGNATURE: MD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST: CH. Chia RN
WITNESS:

Started:	Date: 1/2/19	Time: 1755
Stopped:	Date: 1/2/19	Time: 1812
Amount:	☑ all	(if not all, approx:

	Pre	At 15 Minutes	Post
TEMP	97.7		97.6
PULSE	86		101
BP	99/62		99/67
RESP.	18		18
TIME	1755		1812
NURSE	CH. Chia		CH. Chia

Midway Assessment by: CH. Chia RN
Blood Warmer ? ☐ no ☑ yes:ID#: 1334
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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TRANSFUSION DOCUMENT AND RECORD

Patient Name: Desouza, Eon Victor
MRN: 75911251
Ward: University Apheresis
Date / Time: 01/07/2019 08:49
Patient Blood Type: A POS
Accession #: 19-004-20992
Crossmatch Interp: Compatible
Tech: KFL
Unit / Pool #: W2038 18 695803
Unit Exp.Date / Time: 02/07/2019 23:59
Donor Type: O POS
Product: E0686 RBC LR
Antigen / Attribute:

E Neg JkA Neg K Neg Cw Neg Hgb S Neg
2nd container Apheresis ResLeu:<5log6

Red Cell Products MUST be Started with **0.9% NACL ONLY** / Infused within 4 hr.

INTRA-OPERATIVE INDICATIONS FOR TRANSFUSION

☐ EBL> 15% BV ☐ THROMBOCYTOPENIA
☐ MASSIVE TRANS ☐ COAGULOPATHY
☐ OTHER Indication:

SIGNATURE: MD

Transfusionist and Witness MUST certify:
1. Patient's **Name** and **MRN** on this form and **Wristband** are **Identical**.
2. **Donor #** and **Blood Type** on this form and **Donor Bag** are **Identical**.
3. Patient's consent for transfusion **Signed** and **Witnessed**.

TRANSFUSIONIST:
WITNESS:

Started:	Date: 1/7/19	Time: 1056
Stopped:	Date: 1/7/19	Time: 1101
Amount:	☑ all	(if not all, approx:

	Pre	At 15 Minutes	Post
TEMP	99		98.3
PULSE	80		81
BP	125/73		113/76
RESP.	18		18
TIME	1056		1101
NURSE	CH. Chia		CH. Chia

Midway Assessment by: CH. Chia RN
Blood Warmer ? ☐ no ☐ yes:ID#: 1334
Did Patient have a Transfusion Reaction ?: ☐ YES*
* When YES (See Back of form for REACTION Work-Up)

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