

Patient B

Transfusion Adverse Reaction Event Form

Diagnosis prior to transfusion/infusion: anemia

Indications for transfusion/infusion: _____

PATIENT SYMPTOMS (check all that apply)

Allergic		All Other Reactions	
<input type="checkbox"/> Hives	<input type="checkbox"/> Nausea, vomiting	<input type="checkbox"/> Flushing	<input type="checkbox"/> Oliguria
<input type="checkbox"/> Itching	<input type="checkbox"/> Chills	<input checked="" type="checkbox"/> Rigors	<input type="checkbox"/> Chest pain
	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heat/pain at IV site	<input type="checkbox"/> Back pain
	<input type="checkbox"/> Headache	<input checked="" type="checkbox"/> Shortness of breath	<input type="checkbox"/> Other skin rash
	<input checked="" type="checkbox"/> Fever greater than 1° increase from pre-transfusion temp and greater than or equal to 38°C	<input type="checkbox"/> Facial/tongue swelling	<input type="checkbox"/> Other (specify)
	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hypotension	
	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diffuse hemorrhage
		<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Shock
		<input type="checkbox"/> Red/brown urine	

Additional comments: _____

Duration of symptoms: _____

Pre-medication: No Yes specify drug/dose/route: _____

Pre-transfusion/infusion Temp: 36.8 Pulse: _____ Resp: _____ BP: _____

Post-transfusion/infusion Temp: 38.1 Pulse: _____ Resp: _____ BP: _____ Highest Temp: 38.1

Treatment required for reaction: None Antipyretics Diuretics
 Steroids Antihistamines Blood Cultures ICU Required Supplementary O2

History of fever prior transfusion: Yes No

Is patient currently prescribed? Ace Inhibitor Diuretic Antibiotic

Transfusion/infusion history: Yes, less than 3 months Yes, greater than 3 months No Unknown

Immune-compromised: Yes No Unknown Describe: _____

Previous pregnancies: Less than 3 months Greater than 3 months No Unknown

Known allergies: (list): _____

Transfused/infused under anaesthesia: general local none

Blood Product/Component Type: Red cells Serial / Lot #(s): C055612001002

Volume infused: 150 mL Date/Time Start 14 00 : _____ hrs Restarted Yes No
 Stop 14 15 : _____ hrs

Equipment used: Blood Warmer Rapid Infusion Device IV Pump Re-infusion Device
 Other _____

Reported By: _____ Date/Time _____ : _____ hrs
 (Signature of RN) Nurse

Name of Physician Notified: Doctor Date/Time _____ : _____ hrs

PATHOLOGIST CONCLUSIONS

Type: Allergic Minor severe/anaphylactoid
 Febrile non-hemolytic Hemolytic acute delayed

TRALI Circulatory overload Non-specific (specify): _____
 Other: _____

RECOMMENDATIONS: _____

Medical Director Laboratory (signature) _____ Date: _____

7-4101-104 February 17, 2010