CAMBRIDGE MEMORIAL HOSPITAL

Patient A

Transfusion Adverse Reaction Event Form

Diagnosis prior to transfusion/infusion: anemia

Indications for transfusion/infusion: _____

PATIENT SYMPTOMS (check all that apply)

Allergic

- ☑ Hives
- ☑ Itching

- ☐ Nausea, vomiting
- ☐ Chills
- ☐ Anxiety
- ☐ Headache
- ☐ Fever greater than 1° increase from pre-transfusion temp and greater than or equal to 38°C
- ☐ Jaundice
- ☐ Wheezing

All Other Reactions

- ☐ Flushing
- ☑ Rigors
- ☐ Heat/pain at IV site
- ☑ Shortness of breath
- ☐ Facial/tongue swelling
- ☐ Hypotension
- ☐ Hypertension
- ☐ Tachycardia
- ☐ Red/brown urine

- ☐ Oliguria
- ☐ Chest pain
- ☐ Back pain
- ☐ Other skin rash
- ☐ Other (specify)
- ☐ Diffuse hemorrhage
- ☐ Shock

Additional comments:

Duration of symptoms:

Pre-medication: ☒ No ☐ Yes specify drug/dose/route:

Pre-transfusion/infusion Temp: 37 Pulse: Resp: BP:

Post-transfusion/infusion Temp: 37 Pulse: Resp: BP: Highest Temp:

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 cell | Serial / Lot #(s): C0551211234 56

Volume infused: 100 mL | Date/Time Start 10:00 _____:_____ hrs | Restarted ☐ Yes ☒ No

Stop 10:20 _____:_____ hrs

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

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

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: _____