



NOTIFICATION OF A SUSPECTED TRANSFUSION REACTION

PATIENT DETAILS

CHI Number			
Surname			
Forename			
Date of Birth		Gender	
Hospital		Ward	
Consultant			

RETURN THE FOLLOWING TO BLOOD BANK:

- 1 Notification form completed by ward medical staff
- 2 The donor pack causing the reaction complete with the giving set (needle removed)
- 3 All untransfused components for this patient
- 4 Blood Transfusion sample and request form (post transfusion)
- 5 Any other samples as instructed by Haematologist

CLINICAL DETAILS

Brief medical history														
Reason For Transfusion											Pre-Transfusion Haemoglobin	g/dL		
Previous Transfusion	YES		NO		Previous Transfusion Reaction	YES		NO		Previous Pregnancies	YES		NO	

OBSERVATIONS	TEMPERATURE	BLOOD PRESSURE	PULSE	RESPIRATIONS
PRE TRANSFUSION				
AT TIME OF REACTION				

SYMPTOMS (please tick)

RIGORS/ CHILLS		TACHYCARDIA		VOMITING/NAUSEA	
URTICARA		ITCH/RASH		JAUNDICE	
LUMBAR PAIN		DYSPNOEA		HAEMOGLOBINURIA	
PAIN/HEAT AT INFUSION SITE		O2 SATURATION <90% ON AIR		UNEXPECTED BLEEDING (?DIC)	
OTHER (Please Specify)				VOLUME OF URINE PASSED SINCE REACTION	ml

IMPLICATED COMPONENT DETAILS(Pease tick) Red Cells FFP Platelets Cryo

ABO Group		Rhesus (D)		Donor Pack No.		Expiry Date	
Date /Time Pack Removed from storage (if known)				Was Blood Warmed Before Infusion	Yes / No		
Date / Time Transfusion Commenced				Volume of Blood Infused (approx)	ml		
Date / Time Onset of Symptoms				Date/Time Transfusion stopped			
Number of Units transfused though giving set			Was Anything Injected Into Pack or Giving Set	YES		NO	(IF yes Please Specify)
Details of any other suspected components	1.Donor Pack No		Product		4. Donor Pack No		Product
	2.Donor Pack No		Product		5. Donor Pack No		Product
	3.Donor Pack No		Product		6. Donor Pack No		Product

Please specify treatment given for the reaction:

Doctor Signature:

Print Name:

Page Number :

Date: