

TRANSFUSION REACTION INVESTIGATION FORM

Addressograph or

Patient Name, Date of Birth
Physician, Nursing Unit, and
Date

TO BE COMPLETED BY PERSON REPORTING REACTION

1. Adm. diagnosis: _____ Surgical Proc./date: _____
 2. Component #: _____ Amt. infused: _____ Was blood warmed?____
 3. Record any solution infused with or added to component:

4. Record any medication administered during transfusion:

5. Name of Dr. notified: _____ Date: _____ Time: _____

6. Date of Transfusion: _____

VITAL SIGNS

	Prereaction	Reaction	Postreaction
Time started: _____ Temp. (deg.C)	_____	_____	_____
Time stopped: _____ Pulse	_____	_____	_____
Symptoms began: _____ B. P.	_____	_____	_____

7. Clinical Symptoms:

- | | | |
|--|--|---|
| <input type="checkbox"/> Urticaria/Hives | <input type="checkbox"/> Chilly Sensation | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Arthralgia | <input type="checkbox"/> Shaking chills |
| <input type="checkbox"/> Temp. Elevation | <input type="checkbox"/> Oozing from wound | <input type="checkbox"/> Hematuria |
| <input type="checkbox"/> Perspiration | <input type="checkbox"/> Headache | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Hypertensive | <input type="checkbox"/> Skin pallor | |
| <input type="checkbox"/> Other: _____ | | |

8. Comments: _____

9. Nurse completing this report: _____

Date: _____ Time: _____

*** lab personnel: this original form is retained with other blood bank records after information is entered into the LIS

Procedure Version # : BL 2320.0f1 Transfusion Reaction Investigation Form
