CANADIAN BLOOD SERVICES

777 William Ave. Winnipeg, MB R3E 3R4

TRANSFUSION REACTION INVESTIGATION

PLEASE USE NAME PLATE OR PRINT

PHIN _____

LAST NAME _____

FIRST NAME _____

DOB _____
YYYY - MMM - DD

Male ☐ Female ☐

Diagnosis _____

Reason for Transfusion _____

Reaction Date _____ Time _____

Form Completed By

_____
Print Name Classification Initials

Name of Physician / Authorized Health Care provider Authorizing Investigation:

_____ Time _____

History

Transfusions	☐ Yes <3 mo.	☐ Yes >3 mo.	☐ No	☐ Unknown
Preg. Miscarriages	☐ Yes <3 mo.	☐ Yes >3 mo.	☐ No	☐ Unknown
Immune Compromised		☐ Yes	☐ No	☐ Unknown

Premedication (ie. antipyretics, antihistamines, etc.): ☐ No ☐ Yes

If Yes, Specify Drug(s): _____

Pre Transfusion Hemoglobin _____ g/L

Transfused Under Anesthesia: ☐ No ☐ Yes ☐ General ☐ Local

Vital Signs

Transfusion Reaction Sample Collected at

Facility _____ Ward/Unit _____

Phlebotomist

_____
Print Name Classification Initials

Collection Date _____ Tme _____

PRE Temp _____ Pulse _____ BP _____ O_2 Sat _____

POST Temp _____ Pulse _____ BP _____ O_2 Sat _____

New Onset Clinical Signs and Symptoms

☐ Chills/Rigors	☐ Hemorrhage	☐ Hypoxemia	☐ Shortness of Breath
☐ Urticaria	☐ Hemoglobinuria	☐ Jaundice	☐ Tachycardia
☐ Other Skin Rash	☐ Hypertension	☐ Oliguria	☐ Pain, Specify: _____
☐ Nausea/Vomiting	☐ Hypotension	☐ Shock	☐ Other _____

Measures Taken

☐ None Required

☐ Analgesics	☐ Chest X-Ray	☐ Steroids	☐ Transfusion Stopped
☐ Antibiotics	☐ Diuretics	☐ Supplementary O_2	☐ Transfusion Restarted
☐ Antihistamines	☐ ICU Required	☐ Vasopressors	☐ Patient Blood Culture Ordered
☐ Antipyretics	☐ Mechanical Ventilation	☐ Other, Specify: _____	☐ Component Blood Culture Ordered

Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)

Donor ABO/Rh	Product Type	Donation Number	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

Nursing Clerical Check

Nurse 1 Print name _____ Date/Time _____

Nurse 2 Print name _____ Discrepancies ☐ No ☐ Yes If Yes, Specify _____

Facility Blood Bank Clerical Check ☐ Component(s) Sent for Culture

Print Name _____ Date/Time _____ Discrepancies ☐ No ☐ Yes If Yes, Specify _____

Date / Time Received at Facility Blood Bank	Sample Accession Label	Sample / Req Comparison
Date / Time Received at Centre		Accessioned