

ADVERSE EVENT INVESTIGATION RECORD

(Preliminary Report of Transfusion Reaction)

Privacy Act Statement: The authority to request this information is contained in 5 U.S.C. Section 301 and Department Regulation.										
TRANSFUSION REACTIONS, regardless of severity are to be IMMEDIATELY reported to the Blood Bank. If a TRANSFUSION REACTION is suspected or diagnosed, it is the responsibility of the ATTENDING PHYSICIAN to see that the following occurs.										
(1) Transfusion STOPPED, line kept open with normal saline.					- Post-transfusion urine specimen sent to Laboratory					
(2) Perform a clerical check of patient's arm band, blood component with Pink Tag, and SF-518.					(4) INTACT Blood component, infusion set, IV solutions and completed SF-518 (Section III-Record of Transfusion must be completed) are forwarded to the Blood Bank.					
(3) Post-Transfusion specimens are obtained by the ward/clinic. - One 4 mL EDTA (purple) and one 6 mL plain (red) top tube										
CLINICAL DATA (To be completed by Ward)										
Patient Name:					FMP/SSN:					
Primary Diagnosis:				Current Therapy/Medication:						
Blood Component Transfused: (Check one): <input type="checkbox"/> Red Cells <input type="checkbox"/> Platelets <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate										
Unit Number:		Amount Transfused: mL		Date Transfused:		Time Started:		Time Stopped:		
Pre-medication(s):										
Delayed Transfusion Reaction Suspected:				Date Identified:			Time:			
Vital Signs		BP	TEMP	PULSE	TIME	OBSERVED SIGNS AND SYMPTOMS OF REACTION:				
Pre-Transfusion						<input type="checkbox"/> Chills	<input type="checkbox"/> Fever >2°F	<input type="checkbox"/> Nausea	<input type="checkbox"/> Urticaria	
Post-Transfusion						<input type="checkbox"/> Back Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Anuria	
CLERICAL CHECK (✓) as performed:					<input type="checkbox"/> Hypotension <input type="checkbox"/> Hematuria <input type="checkbox"/> Flushing <input type="checkbox"/> Dyspnea					
ABO/Rh Label <input type="checkbox"/>		Arm Band <input type="checkbox"/>			<input type="checkbox"/> Shock <input type="checkbox"/> Oliguria <input type="checkbox"/> Other					
Unit Number <input type="checkbox"/>		SF-518 <input type="checkbox"/>		Pink Tag <input type="checkbox"/>		Reported by:		Date:	Time:	
DO NOT WRITE BELOW THIS LINE -BLOOD BANK USE ONLY										
Date/Time received in Blood Bank:										
CLERICAL CHECK (✓) if information is correct:										
Patient Name <input type="checkbox"/>		SF-518 <input type="checkbox"/>		Blood Issue Pink Tag <input type="checkbox"/>		Pre-Txn specimen <input type="checkbox"/>		Post-Txn specimen <input type="checkbox"/>		
Unit # <input type="checkbox"/>		Pt. Hx Card <input type="checkbox"/>		BB Comp/Manual Issue Log <input type="checkbox"/>		ABO/Rh Type <input type="checkbox"/>		Unit Seg # XM <input type="checkbox"/> RT <input type="checkbox"/> AT <input type="checkbox"/>		
Clerical discrepancy(ies) noted:						ABO/Rh Testing				
Visual Check: Appearance of Serum				DAT Testing			Anti-A	Anti-B	Anti-D	Interp:
Pre-Txn		NL <input type="checkbox"/> Hemolyzed <input type="checkbox"/> Icteric <input type="checkbox"/>		Polyspecific:	Anti-IgG:	Anti-C3d:	Interp:			
Post-Txn		NL <input type="checkbox"/> Hemolyzed <input type="checkbox"/> Icteric <input type="checkbox"/>		Polyspecific:	Anti-IgG:	Anti-C3d:	Interp:			
Post-Txn Urinalysis: Free Hemoglobin: <input type="checkbox"/> Yes <input type="checkbox"/> No						Tech:				
Pathologist Review: <input type="checkbox"/> Acute Hemolytic <input type="checkbox"/> Delayed hemolytic <input type="checkbox"/> Febrile <input type="checkbox"/> Allergic <input type="checkbox"/> Hypervolemic <input type="checkbox"/> Underlying disease <input type="checkbox"/> TRALI <input type="checkbox"/> Other _____										
Continue with COMPREHENSIVE Work up? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Attending Physician Notified: _____ Pathologist: _____ By: _____ <div style="display: flex; justify-content: space-around;"> Date/Time Date/Time </div>										
ADDRESSOGRAPH					INVESTIGATION REVIEW:					
					_____ Medical Director Date					
					_____ QA Coordinator Date					