ROYAL CHILDREN'S HOSPITAL

THE ROYAL WOMEN'S HOSPITAL

BLOOD TRANSFUSION REACTION REPORT

To be used for investigation of suspected reactions to fresh blood products (blood, platelets, FFP, cryoprecipitate, granulocytes)

Affix patient ID sticker here

Please complete form and forward with appropriate blood specimens and used pack to the Hospital Blood Bank: RCH Xn 5829, RWH Xn 2036. For advice re diagnosis, management and investigation of suspected transfusion reactions please page the on call Haematologist via switchboard (RCH dial 91, RWH dial 92).

Ward/Unit: _____ Date: _____

Clinical Diagnosis: _____

Product being transfused: _____ Time commenced: _____

Donation (pack) number: _____ Volume transfused: _____ mls

Clerical Check (please circle)

Patient ID correct	Yes / No
Blood pack correct	Yes / No
Blood Transfusion Record correct	Yes / No

Temperature in the 24 hours prior to transfusion: (Please tick)

FEBRILE ☐ AFEBRILE ☐ (<38°C)

Vital signs

	Time	Temperature	Respiration	B.P.	Pulse
Pre Reaction					
At time of Reaction					

Signs and Symptoms – Please Tick

Fever	☐	Lower Back Pain	☐	Skin Pallor	☐
Chills	☐	Chest Pain	☐	Dark Urine	☐
Nausea/Vomiting	☐	Anxiety	☐	Dyspnoea	☐
Hives/itching	☐	Headache	☐	Bleeding from wound or IV site	☐
Other (specify below)	☐				

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Please document any blood products given in previous 12 hours:

Donor Unit number	Product type (eg FFP)	Date	Time unit		Volume given	Reaction Yes/No
			Started	Stopped		

(Add attachment if more space required)

Reviewing doctor:

Name: _____ Tel. Ext./Page _____

(PRINT)

Signature: _____ Date: _____