Children's Hospitals and Clinics of Minnesota

Transfusion Reaction Report

Diagnosis: _____

Patient Category: ☐ Hematology ☐ Oncology ☐ Medical ☐ Surgical ☐ Trauma ☐ Neonatal

Patient and Blood Component/Product Unique Identifier Verification (Clerical Check)

Is the information **IDENTICAL** on the following: ▪ Patient ID band ▪ Blood component/product label ▪ Blood Tag? ☐ **Yes** ☐ **NO**
IF NO, contact Blood Bank IMMEDIATELY. **Another Patient may be at risk.** Date/Time Transfusion Service notified: _____

Clinical History (Check all that apply)

☐ Pre-existing fever ☐ History or evidence of circulatory overload ☐ Immune-compromised (specify): _____

☐ Transfused under anesthesia ☐ Transfusion pre-medication (specify):_____

Patient currently prescribed: ☐ Diuretic ☐ Antibiotic(s)_____

History of Transfusion: ☐ No ☐ Unknown ☐ Yes (within 3 months) ☐ Yes (>3 months)

Patient Location, Date and Time of Transfusion Reaction

Date	Location	Time Transfusion **Started**	Time RX **Occurred**	Time Transfusion **Stopped**	Transfusion: **Completed or Interrupted**

Clinical Signs and Symptoms

Vital Signs	**Before**	**During**	**After**
Time			
Temp			
B.P.			
Pulse			

Clinical Signs and Symptoms: Check all that apply.

- ❑ Urticaria (hives)
- ❑ Skin rash
- ❑ Pruritus (itching)
- ❑ Headache
- ❑ Fever (≥39°C or ≥1°C rise above baseline)
- ❑ Chills
- ❑ Rigors (shaking)
- ❑ Nausea/vomiting
- ❑ Flushing
- ❑ Facial or tongue swelling
- ❑ Restlessness/Anxiety
- ❑ Joint/muscle pain
- ❑ Lumbar/back pain
- ❑ Chest pain
- ❑ Heat/pain at IV site
- ❑ Dizziness
- ❑ Jaundice
- ❑ Oliguria
- ❑ Hematuria (Red or brown urine)
- ❑ Dyspnea (Shortness of breath)
- ❑ Wheezing
- ❑ Hypoxemia: SpO2_____% or PaO_2_____mmHg on
  - ☐ Room air
  - ☐ Supplementary O_2 _____L/min
- ❑ Hypertension: Rise in SBP ≥30 mmHg
- ❑ Hypotension: Drop in SBP ≥30 mmHg
- ❑ Tachycardia (HR rise > 40bpm)
- ❑ Shock
- ❑ Diffuse hemorrhage
- ❑ Other_____

Blood Component and Equipment Information:

Blood Component	**Unit Number**	**Volume Transfused**
Filters or Equipment Used	☐ Standard blood filter ☐ Other blood filter ☐ Blood warmer ☐ Rapid infusion device ☐ Other_____	

Treatment Measures and Notification:

Treatment Measures Taken (check all that apply)

- ❑ Antipyretics
- ❑ Diuretics
- ❑ Analgesic
- ❑ Antihistamines
- ❑ Antibiotics
- ❑ Vasopressor
- ❑ Steroids
- ❑ Supplementary O_2
- ❑ Blood Cultures collected
- ❑ Chest X-ray
- ❑ Transfer to PICU
- ❑ Ventilation/Duration _____
- ❑ Other: _____

Notifications:

Physician (name): Date/time: | Blood bank (name): Date/time:

Reported By: (signature) _____ **Print Name:** _____ **Date:**_____

TRANSFUS

PLACE PATIENT LABEL HERE

Children's Hospitals and Clinics of Minnesota

Transfusion Reaction Report

Transfusion Medicine Service-Laboratory Use Only TRXR_____

Pathologist Report:

Additional testing recommended:

- ❑ None
- ❑ Hgb (Accession Number: _____)
- ❑ Bilirubin (Accession Number: _____)
- ❑ Haptoglobin (Accession Number: _____)
- ❑ Urine Hgb (Accession Number: _____)
- ❑ BNP (Accession Number: _____)
- ❑ Bacterial cultures
  - Date/Time of gram stain and culture: _____
  - Sample source: ☐ bag ☐ Segment ☐ Other: _____
  - Culture (TRXN Accession Number: _____)
- ❑ Other (Document Accession Number):
  _____

Conclusion:

- ❑ No Transfusion RX
- ❑ Unable to determine if related to transfusion
- ❑ Allergic
- ❑ Mild Circulatory Overload
- ❑ Febrile, Non-Hemolytic
- ❑ Severe Allergic/ Anaphylactic/ Anaphylactoid
- ❑ Acute Hemolytic
- ❑ Anaphylatic Shock
- ❑ Bacterial Contamination
- ❑ Possible TRALI
- ❑ TRALI
- ❑ Delayed Hemolytic
- ❑ Delayed Serologic transfusion reaction- Antibody ID:_____
- ❑ Hypotensive Reaction
- ❑ TACO
- ❑ TAD
- ❑ PTP
- ❑ TA-GVHD
- ❑ Hypocalcemia
- ❑ Incompatible Transfusion: Antibody ID:_____
- ❑ Other_____ _____

Relationship, Severity, and Outcome

Relationship of reaction to transfusion: ☐ Definite ☐ Probable ☐ Possible ☐ Doubtful ☐ Ruled out ☐ Not determined

Severity (grade) ☐ 1 (Non-severe) ☐ 2 (Severe) ☐ 3 (Life-threatening) ☐ 4 (death) ☐ Not determined

Outcome ☐ Minor or no sequelae ☐ Major or long-term sequelae ☐ Death ☐ Not determined

Relationship to death ☐ Definite ☐ Probable ☐ Possible ☐ Doubtful ☐ Ruled out ☐ Not determined

Blood Supplier/Manufacturer notified ☐ No ☐ Yes→ Supplier Contact: _____ Date/time:_____

Pathologist Comments and Recommendations:

Transfusion Service Medical Director or Pathologist:

Signature: _____ Date: _____ Time: _____

PLACE PATIENT LABEL HERE