Write the patient's admitting diagnosis, not "TACO"

As much information as possible regarding reason for transfusion

Name of the doctor taking care of the patient right now

List any medication that could mask our vital signs i.e. beta blockers, antipyretics

New symptoms post-transfusion

Redo the two nurse check, preferably two different nurses from the original check

CANADIAN BLOOD SERVICES

WINNIPEG CENTRE

777 William Ave, Winnipeg, MB R3E 3R4

TRANSFUSION REACTION INVESTIGATION

Diagnosis: upper/lower GI bleed

Reason for Transfusion: active GI bleed/hypotension/shock

Reaction Date ________ (YYYY-MM-DD) Time ________ (HH:MM)

Form Completed By

Print Name ________ Classification ________ Initials ________

Name of Physician/Authorized Health Care Provider Authorizing Investigation: ________ Time ________ (HH:MM)

PLEASE USE NAME PLATE OR ENTER

PHIN ________

LAST NAME ________

FIRST NAME ________

DOB ________ (YYYY-MM-DD)

☐ Male ☐ Female

This is where the report will be sent when the investigation is complete. CBS will forward it if the patient is transferred elsewhere

Transfusion Reaction Sample Collected at

Facility ________ Ward/Unit ________

Phlebotomist

Print Name ________ Classification ________ Initials ________

Collection Date ________ (YYYY-MM-DD) Time ________ (HH:MM)

Must match the sticker on the tube, same as the crossmatch

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 (i.e. antipyretics, antihistamines, etc.) ☐ No ☐ Yes

If Yes, Specify Drug(s): ________

Pre Transfusion Hemoglobin 53 g/L

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

Vital Signs

PRE Temp ____ Pulse ____ BP ____ O_2 Sat ____

POST Temp ____ Pulse ____ BP ____ O_2 Sat ____

"Pre" = vital signs before the transfusion started

"Post" = the worst vital signs after the transfusion reaction started

NEW ONSET Clinical Signs and Symptoms

☐ Chills/Rigors ☐ Hemorrhage ☐ Jaundice ☑ Shortness of Breath

☐ Urticaria ☐ Hemoglobinuria ☐ Oliguria ☐ Tachycardia/Arrythmia

☐ Pruritus ☑ Hypertension ☐ Severe Allergic Reaction ☐ Headache

☐ Other Skin Rash ☐ Hypotension ☑ Severe Respiratory Distress ☐ Pain: Specify ________

☐ Nausea/Vomiting ☑ Hypoxemia ☐ Shock ☑ Other peripheral edema

Reaction Type:

☐ Minor

☑ Major

Measures Taken

☐ None Required

☐ Analgesics ☑ Chest X-Ray ☐ Steroids ☐ Transfusion Stopped

☐ Antibiotics ☑ Diuretics ☑ Supplementary O2 ☐ Transfusion Restarted

☐ Antihistamines ☐ ICU Required ☐ Vasopressors ☐ Patient Blood Culture Ordered

☐ Antipyretics ☐ Mechanical Ventilation ☐ Other, Specify: ________ ☐ Component Blood Culture Ordered

What was done to treat the patient up to the time this form is being completed?

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

Donor ABO/Rh	Product Type	Donation Number	Volume Given (mL)	Date/Time Started (YYYY-MM-DD HH:MM)	Date/Time Finished (YYYY-MM-DD HH:MM)	Expiry Date (YYYY-MM-DD)	Product Code #	Product Modifiers

Derivative Transfusion Reaction (E.g. Albumin, IVIG, Factor Concentrates)

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV / IM)	Frequency	Time Started (HH:MM)	Time Finished (HH:MM)	Expiry Date (YYYY-MM-DD)

Stickers or written numbers from blood products. If more than four, include the last four infused

Nursing Clerical Check

Nurse 1 Print Name ________ Date/Time (YYYY-MM-DD HH:MM) ________

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

Blood bank use only