

BHABHA ATOMIC RESEARCH CENTRE HOSPITAL BLOOD CENTRE

WHOLE BLOOD / BLOOD COMPONENT /BLOOD PRODUCT TRANSFUSION REACTION FORM

(To be sent to Department of Transfusion Medicine / Blood Centre after transfusion)

PATIENT'S NAME							
(Full Name In Capitals)		NAME		MIDDLE NAME		SURNAME	
AGE		SEX		CHSS No		WARD	
PHYSICIAN/SURGEON'S NAME							
DIAGNOSIS							
INDICATION OF TRANSFUSION							
PATIENT'S BLOOD GROUP				ABO:		Rh:	
COMPONENT TRANSFUSED (PRBC/FFP/PLT etc)							
BLOOD BAG/ UNIT No.							
EXPIRY DATE							
DATE & TIME OF START OF TRANSFUSION					DATE & TIME OF COMPLETION/STOP		
RATE OF TRANSFUSION				DROPS PER MINUTE OR TOTAL TIME TAKEN			
QUANTITY OF BLOOD TRANSFUSED				ML			

CLINICAL OBSERVATION:

GENERAL CONDITION	PRE TRANSFUSION	DURING TRANSFUSION	POST TRANSFUSION
PULSE			
RESP.			
TEMP.			
B.P.			
RIGOR			
CHILLS			
MYALGIA			
URTICARIA			
OTHER OBSERVATION			

Signature of Medical Officer / Nurse with date

**Note: In any case of transfusion reaction, inform the blood centre staff immediately.
Send blood bag, transfusion set, Post – transfusion sample (EDTA and plain), urine sample.**

Send the following for lab investigations:

1. Repeat ABO & Rh (D) Grouping- Blood Centre
2. Repeat Antibody Screen and Cross Match- Blood Centre
3. Indirect/ Direct Antiglobulin Test- Blood Centre
4. Complete Blood Count (CBC) - Hematology/ Clinical pathology
5. Urine for routine microscopy- Clinical pathology
6. Coagulation Screen- Hematology/ Clinical pathology

Send clotted Blood sample to Biochemistry Lab for:

7. Renal function test (urea, creatinine and electrolytes)
8. Liver function tests (bilirubin, ALT and AST)

Send Blood culture in special blood culture bottles to Microbiology Lab.

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TRANSFUSION REACTION WORK-UP FORM

PATEINT'S NAME (Full Name In Capitals)							
			NAME		MIDDLE NAME		SURNAME
AGE		SEX		CHSS No		WARD	
PHYSICIAN/SURGEON'S NAME							
DIAGNOSIS							
INDICATION OF TRANSFUSION							
PATIENT'S BLOOD GROUP				ABO:		Rh:	
COMPONENT TRANSFUSED (PRBC/FFP/PLT etc)					DATE OF TRANSFUSION		
BLOOD BAG/ UNIT No.					DATE OF REACTION		
EXPIRY DATE							

Clinical Status of Patient:

Respiratory system:

Renal:

CVS:

GIT:

CNS:

Liver:

H/o Previous Transfusion, Pregnancy, Transplantation:.....

H/o Drug intake:.....

Any other infusion through B.T. set:.....

Reaction details:.....

Received if Yes/No:

Reaction form (duly filled):.....

Blood Bag/Bags along with transfusion set:.....

Post transfusion sample:.....

Date & time at which blood / Blood component was issued:.....

Date & time at which blood / Blood component was transfused:.....

Date & time at which reaction occurred:.....

Date & time at which sample/reaction form were sent to blood centre.....

Amount of Blood/Blood Component Transfused:.....

Rechecking of Records:

Identification of Patient:.....

Cross match file.....

Issue Register.....

Blood Grouping Register.....

Visual Examination of Bag/Transfusion set.....

Investigations:

Supernatant of Sample:

Pre Tx Sample:.....

Post Tx Sample:.....

Bag Sample:.....

Blood Group:

Pre Tx Sample:.....

Post Tx Sample:.....

Bag Sample:.....

Indirect and Direct Coombs Test (ICT/DCT):

Pre Tx Sample:.....

Post Tx Sample:.....

Repeat cross match of blood bag Sample with

Major (RT)	Major (37 ⁰) AHG Phase	Minor (RT)
Pre Tx Sample		
Post Tx Sample		

Evidence of Hemolysis:

Hemoglobin: Pre Tx:.....Post Tx:.....

Serum Bilirubin:.....

Urine for blood:.....

Urine Hemosiderin:.....

Coagulation Status:

PT/aPTT:.....

Platelet Count:.....

Blood Culture:.....

Peripheral Blood Smear:.....

Blood Bag details:

Type of Blood Bag:.....

Lot No:....., Date of Collection:.....

Segment No:.....Date of Expiry:.....

Cross Match Details:

Date of Cross match:.....

Emergency/Routine:.....

Name of staff who cross matched the unit:.....

Date and Time of Issue:.....

Interval between issue and transfusion:.....

Where was blood kept during that interval:.....

Was the blood warmed before transfusion (method if yes):.....

If Blood bag has been previously Cx-matched/issued:

Date of Cx Match	Date/time of Issue	Date of Receive Back

Donor Details

Name:.....

Age/Sex.....

Address:.....

Phone.....

Date of Collection:.....Place of Collection.....

Name of Phlebotomist / Assistant:.....

Type of Donor VD / RD.....

Any special Investigation.....

Inference:

.....
.....

Signature of Technical Officer

Signature of Medical Officer