

TRANSFUSION REACTION REPORT

Duck, Daffy
 MRN: 5264710
 DOB: 23 Jul 1942
 PHN: 9157424256

M 67

- Laura Secord Hospital Port Coquitlam Memorial Hospital
 Fraser Valley Hospital Queen Elizabeth Regional Hospital

Diagnosis: Bowel Obstruction

Indication for Transfusion: Coagulopathy

- Category: Hematology/BMT Oncology Medical Surgical Obstetrics/Gyn/Perinatal Trauma Neonatal

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

Is the information IDENTICAL on all the following: • Patient ID band • Issue document/tag • Blood component/product label? YES NO
 IF NO, contact TMS/Lab IMMEDIATELY. Another patient may be at risk. Date /Time TMS/Lab notified:

2. Clinical History (Check all that apply)

- Pre-existing fever History or evidence of circulatory overload Immune-compromised (specify):
 Transfused under GENERAL anesthesia Transfused under REGIONAL anesthesia Transfusion pre-medication (specify):
 Patient currently prescribed: ACE inhibitor Diuretic Antibiotic(s)
 History of transfusion: No Unknown Yes (within 3 months) Yes (> 3 months)
 History of pregnancies/miscarriages: No Unknown Yes (within 3 months) Yes (> 3 months)

3. Location, Date, and Time of Transfusion Reaction

- Patient location: ICU ER Medical ward Surgical ward OR PAR OB/Gyn Outpatient Chronic Care

Date (dd/mm/yyyy)	Time Transfusion Started	Time Reaction Occurred	Time Transfusion Stopped	Time Transfusion Restarted (Quick Reference Guide)
07 Aug 2009	3 rd unit 1700	1820	1820	1845 Transfusion completed at 2010

4. Clinical Signs and Symptoms

Pre-transfusion	Temp: 36.8 °C (0)	BP: 130/78	Pulse: 75	Respiratory Rate: 16
Post-transfusion	Temp: 37.0 °C (0) (Highest)	BP: 130/80	Pulse: 80	Respiratory Rate: 20

Clinical Signs and Symptoms: Check all that apply.

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Urticaria (rash) | <input type="checkbox"/> Joint/muscle pain | <input type="checkbox"/> Dyspnea (shortness of breath) |
| <input type="checkbox"/> Pruritus (itching) | <input type="checkbox"/> Back pain | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hypoxemia: SpO ₂ _____ % or PaO ₂ _____ mm Hg on _____ |
| <input type="checkbox"/> Fever (Oral T ≥38°C AND ≥1°C rise above baseline temp) | <input type="checkbox"/> Heat/pain at IV site | <input type="checkbox"/> Room air |
| <input type="checkbox"/> Chills (sensation of cold) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Supplementary O ₂ _____ L/min |
| <input type="checkbox"/> Rigors (involuntary shaking) | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Flushing | <input type="checkbox"/> Red or brown urine | <input type="checkbox"/> Hypotension (SBP drop ≥ 30mmHg) |
| <input type="checkbox"/> Skin rash other than urticaria | <input type="checkbox"/> Oliguria | <input type="checkbox"/> Tachycardia (HR rise > 40bpm) |
| <input type="checkbox"/> Restlessness/anxiety | <input type="checkbox"/> Diffuse hemorrhage | <input type="checkbox"/> Shock |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Facial or tongue swelling | |

Other relevant clinical information:

5. Blood Component/Product(s) and Equipment Information (Attach sheet with additional information if needed.)

5a. Blood Component/Product Type	Unit or Lot Number	Volume Transfused (mL or # of vials)
Plasma	① C051009391148	① 245
	② C051009588210	② 237
	③ C051009433875	③ 361

- 5b. Filters or Equipment Used Standard blood filter Other blood filter IV pump Blood warmer Rapid infusion device
 Re-infusion device Cell saver Details:

6. Measures and Notifications

6a. Treatment Measures Taken (Check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Antipyretics | <input type="checkbox"/> Diuretics → <input type="checkbox"/> Effective | <input type="checkbox"/> Analgesic | <input type="checkbox"/> ICU |
| <input checked="" type="checkbox"/> Antihistamines | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Supplementary O ₂ | <input type="checkbox"/> Ventilation → Duration: _____ |
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Vasopressor | <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Blood samples taken |
| <input type="checkbox"/> Other: | | | |

Notifications: Physician (name): Dr A. Oudin Date/Time: 07 Aug 2009 1825 TMS/Lab(name): _____ Date/Time: _____

6b. Reported By: (signature) Curt Conley
 Name (print): CURT CONLEY Designation RN Date/Time: 07 Aug 2009 2030