CHART COPY

Name

Admit #: Med Rec #:

Physician

SSN: DOB:

Address

YOUR HOSPITAL WASHINGTON, DC	Specimen No.

BLOOD BANK II - TRANSFUSION WORKSHEET

DATE ORDERED	BY	☐ ROUTINE ☐ STAT ☐ PRE-OP	TECH	DATE DONE

TRANSFUSION RECORD I certify that I have identified the recipient from inspection of wrist band and that the Name & Hospital Number are the same as indicated. I further certify that the Donor Blood Label (ABO&RH) are the same as indicated on this form, and that the donor blood is of normal color and appearance.	DATE PROCESSED

SIGNATURE OF TRANSFUSIONIST	DATE GIVEN	TIME STARTED	TIME FINISHED	AMOUNT GIVEN

NOTE - IF REACTION OCCURS

1 - STOP TRANSFUSION
2 - NOTIFY THE BLOOD BANK
3 - COMPLETE TRANSFUSION REACTION REPORT

☐ CROSSMATCH	UNIT #	OF UNITS REQUIRED
DONOR UNIT	UNIT #	EXPIRATION DATE

☐ PC ☐ WB

PATIENT	ABO	Rh	ANTIBODY SCREEN
☐ DONOR	ABO	Rh	ANTIBODY SCREEN

☐ OTHER

COMPATIBLE IN	BY	MAJOR PS/DC	SAL ☐ ALB ☐ AHG ☐

BLOOD COMPONENTS

☐ PLATELETS ☐ CRYO ☐ FFP ☐ OTHER

NOTE - THIS UNIT WILL BE RESERVED FOR "72" HOURS.