Memorial
Hospital

TRANSFUSION RECORD

Name: Location:
MR #: Billing #:
Messages:
Antibodies: Patient ABO/RH:

Unit #: Unit ABO/Rh:
Expiration Date/Time: Product :
Volume :
Crossmatch: Instruction:

Armband #: Antigen:
Comments :

TRANSFUSION CERTIFICATION: I/We certify that I/We have identified the recipient from inspection of the hospital ID band and the Blood Bracelet and that the name and hospital number and blood label number of the bands and requisition are identical. I/We further certify that the blood label has the same unit number, ABO group and Rh type as this requisition.

Name:	Name/Witness:	Date & Time Started:

TRANSFUSION RECORD:

Time	Vital Signs	Temp	B/P	Pulse	Resp
____	Start/Pre	____	____	____	____
____	15 Min	____	____	____	____
____	30 Min	____	____	____	____
____	60 Min	____	____	____	____
____	90 Min	____	____	____	____
____	120 Min	____	____	____	____
____	150 Min	____	____	____	____
____	180 Min	____	____	____	____
____	210 Min	____	____	____	____
____	240 Min	____	____	____	____
____	Stop/Post	____	____	____	____

Stopped By / Unit: _____
Amount Infused: _____
End Date & Time: _____
Reaction? ☐ Yes ☐ No

☐ Blood warmer used
☐ Leukopoor unit/filter used

COMPLETE ONLY IF TRANS RX IS REPORTED
FOLLOW INSTRUCTIONS IF A REACTION IS SUSPECTED
Stop the transfusion keeping a line open with a slow saline drip.
Notify the physician and the Blood Bank immediately.
Check patient ID on wrist band and blood product bag.
Draw two pink top tubes according to Blood Bank protocol.
Take Sample and Blood Product with infusion set intact to Blood Bank.
Return Blood Bank copy of this completed form.
Record patient Symptoms:

☐ Fever ☐ Change in B/P ☐ Other: _____
☐ Chills ☐ Change in Pulse

☐ Urticaria ☐ Hemoglobinuria
☐ Flushing ☐ Chest Pain

☐ Nausea ☐ Back Pain

Patient Diagnosis: _____

Reported to Dr. _____ by _____ RN

Physician Requesting workup for suspected reaction:

_____ (Print)

Phone number / Beeper:

_____