

**THE UNIVERSITY
OF KANSAS HOSPITAL**

3901 Rainbow Boulevard
Kansas City, Kansas 66160

**INVESTIGATION OF
SUSPECTED TRANSFUSION
REACTION**

Do not write in this box



Name: _____

DOB: _____

MR#: _____

NURSING OR TRANSFUSIONIST – COMPLETE PAGE 1

FOR ACUTE REACTION other than allergic (itching and hives only):

1. **STOP TRANSFUSION IMMEDIATELY.** Hang new 0.9% saline and keep the IV open with 0.9% saline. Notify the physician.
2. Notify the Blood Bank & order Transfusion Reaction Labs
3. Draw 6mL (pink) EDTA (adults/pediatrics) OR 0.5mL purple EDTA tube (neonates)- send to Blood Bank
4. **HAND DELIVER** the completed form, the unit bag, administration solution and intact IV set to the Blood Bank (room 1410 by the top of the escalators)
5. Send first voided urine specimen to the lab (marked "Transfusion Reaction Urine")

REACTION DESCRIPTION	PATIENT INFORMATION																															
<p>Reaction Date: _____ Time: _____</p> <p>Blood Component Unit # _____</p> <p>Component: <input type="checkbox"/> RBC <input type="checkbox"/> PLT <input type="checkbox"/> FFP <input type="checkbox"/> Other: _____</p> <p>Amount transfused: _____</p> <p>Check Reaction Symptom(s) Observed:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Elevated temp > 1°C or 2°F</td> <td><input type="checkbox"/> Chills</td> </tr> <tr> <td><input type="checkbox"/> Hives/Local Erythema</td> <td><input type="checkbox"/> Hypotension</td> </tr> <tr> <td><input type="checkbox"/> Dyspnea</td> <td><input type="checkbox"/> Jaundice</td> </tr> <tr> <td><input type="checkbox"/> Hematuria/Dark Urine</td> <td><input type="checkbox"/> Anaphylaxis</td> </tr> <tr> <td><input type="checkbox"/> Failure to clot</td> <td><input type="checkbox"/> Flank/lumbar pain</td> </tr> <tr> <td><input type="checkbox"/> Cough</td> <td><input type="checkbox"/> Restlessness/Anxiety</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Excessive bleeding from operative site</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Pain/Other (describe type & location if applicable): _____</td> </tr> </table>	<input type="checkbox"/> Elevated temp > 1°C or 2°F	<input type="checkbox"/> Chills	<input type="checkbox"/> Hives/Local Erythema	<input type="checkbox"/> Hypotension	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hematuria/Dark Urine	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Failure to clot	<input type="checkbox"/> Flank/lumbar pain	<input type="checkbox"/> Cough	<input type="checkbox"/> Restlessness/Anxiety	<input type="checkbox"/> Excessive bleeding from operative site		<input type="checkbox"/> Pain/Other (describe type & location if applicable): _____		<p>Diagnosis: _____</p> <p>IV Solutions/Medication in-line with blood component? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, what?</i> _____</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left;">Vitals</th> <th style="text-align: center;">Pre-Reaction</th> <th style="text-align: center;">Post-Reaction</th> </tr> </thead> <tbody> <tr> <td>Temp:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>B/P:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Pulse:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>SV02</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table> <p>Highest Temp 24hr prior to transfusion: _____</p>	Vitals	Pre-Reaction	Post-Reaction	Temp:	_____	_____	B/P:	_____	_____	Pulse:	_____	_____	SV02	_____	_____
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NURSING ACTION	PATIENT HISTORY
<p>Does the patient's wristband identification match that on the component unit label & Transfusion Record Form?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No if No, Please explain: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Has the patient had a blood component transfusion at another facility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes Facility name: _____ Date of transfusion _____</p> <p>Any previous reactions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, provide details below if available: _____</p> <p>_____</p>

Signature of Reporting RN: _____ Date: _____ Time: _____

<p style="text-align: center;">THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160</p> <p style="text-align: center;">INVESTIGATION OF SUSPECTED TRANSFUSION REACTION</p>	<p>Do not write in this box</p>	<p>Name: _____</p> <p>DOB: _____</p> <p>MR#: _____</p>
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Date/Time Reported: _____

LABORATORY - COMPLETE PAGE 2

Clerical Check on unit, patient MR# & paperwork: _____ NO discrepancies detected
 _____ Discrepancies detected (describe if present): _____

Performed by: _____

TIER I: Initial Investigation			TIER II: Suspected Hemolytic		
Test	Pre-Transfusion Specimen	Post-Transfusion Specimen	Test	Pre-Transfusion Specimen	Post-Transfusion Specimen
Visual Inspection for Free hemoglobin or Icterus: ABO & Rh typing Direct Antiglobulin (DAT) Test: Urine free Hgb (by dipstick) <i>If pos, do microscopic check for intact RBCs.</i>	_____ _____ _____ (perform if Post is discrepant) _____ (perform if Post is discrepant)	_____ _____ (redraw if needed) _____ _____ _____ <i>Intact RBCs:</i> Yes <input type="checkbox"/> No <input type="checkbox"/>	ABO & Rh typing: Antibody screen: Direct Antiglobulin Test: Crossmatch: Hgb & Hct: Bilirubin - Total: - Direct: Additional Tests:	_____ _____ _____ _____ _____ Hgb__Hct__ _____ _____ _____	_____ _____ _____ _____ _____ Hgb__Hct__ _____ _____ _____

Bacterial culture & Gram stain on unit if >1°C rise in temperature following platelet transfusion or >2°C rise in temperature following other components.

Gram Stain result: _____ Culture result: _____

Technologist Signature: _____ Date: _____

IMPORTANT	INTERPRETATION:
<p>Are results suggestive of a hemolytic reaction, bacterial contamination, or other potentially life threatening reaction?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, contact the pathologist or resident on call immediately.</p> <p>Physician contacted: _____ Date: _____ Time: _____ Tech: _____</p>	<p><u>Resolution of symptoms/Reaction type:</u></p> <p>Physician Signature: _____ Date: _____ Time: _____</p>