Transfusion Reaction Reporting Form

Please complete **ALL** sections of this form fully.
If *Not Applicable,* write N/A in the relevant section.

NBS Use Only # _____
☐ Pending ☐ Completed ☐ DNP

PATIENT IDENTIFICATION			
Surname:		First Name:	
Hospital:		Ward:	Hospital #
Age:	☐ Male ☐ Female	Patient's Blood Group:	

TRANSFUSION INFORMATION			
Diagnosis and Indication for Transfusion:			Pre-Transfusion Hb: g/dL
Blood Product: ☐ Whole Blood ☐ Packed Red Cells ☐ FFP ☐ Platelet Concentrate			
Unit Number:	Blood Group of Unit:	Volume transfused:	ml
Date Transfusion started:		Time Transfusion started:	
Date Reaction observed:		Time Reaction observed:	
Unit Numbers transfused before reaction:			
Any Previous Transfusion? ☐ Yes ☐ No		Any Previous Reaction? ☐ Yes ☐ No	

SYMPTOMS (tick as many apply)

☐ Itching	☐ Dyspnoea	☐ Back/flank pain
☐ Chills/Rigors	☐ Chest pain / Tight chest	☐ Oliguria
☐ Fever _____ °C	☐ Anxiety	☐ Dark urine
☐ Nausea	☐ Restlessness	☐ Unexplained bleeding
☐ Rash	☐ Palpitations (pulse = _____ bpm)	☐ Other _____
☐ Urticaria	☐ Hypotension (BP = _____ mmHg)	☐ Other _____

MANAGEMENT	
Outcome: ☐ Complete Recovery ☐ Recovered with Complication ☐ Death	
Specimens accompanying this form:	☐ 2ml patient's blood sample (opposite arm) in EDTA tube ☐ 5ml patient's blood sample (opposite arm) in plain tube ☐ 20ml urine (if applicable) ☐ All blood bags and unused units with attached giving set
Reporting Physician: Date: Contact Number:	

Please return this form with samples and blood bags to Hospital Blood Bank as soon as possible