REPORT OF A SUSPECTED ADVERSE TRANSFUSION REACTION

Western Cape Blood Service
Do something remarkable

In the event of a suspected adverse transfusion reaction, please complete this form and return it to your nearest Blood Bank along with **two post-transfusion EDTA samples** from the patient, all used and unused units, and all giving sets.

a) Patient Information (patient hospital label can be placed below)

Patient's Surname																	
First Name																	
Hospital Number																	
Date of Birth	D	D	M	M	Y	Y	Y	Y	Hospital					Ward			

b) Transfusion Details & Clinical Information

Transfusion started at (date & time) _____ Reaction observed at (date & time) _____

Blood product(s) administered _____ Volume administered before reaction noted _____

Serial number(s) of suspected unit(s) _____

Was this blood product meant for transfusion to this patient? **(Circle)** Yes | No (If No, please report urgently to the Blood Bank as a misdirected transfusion)

Patient's primary diagnosis _____

Indication for transfusion _____

To your knowledge, has the patient had a previous transfusion reaction? _____

d) Patient Vital Signs

Patient weight (for neonatal/paediatric cases): _____

Pre-transfusion	BP:	Pulse:	Temp:	O_2 saturation:
15 minutes after starting transfusion	BP:	Pulse:	Temp:	O_2 saturation:
Post-transfusion or termination of transfusion	BP:	Pulse:	Temp:	O_2 saturation:

e) Signs of Adverse Reaction (mark patient's symptoms with 'X')

Pyrexia		Facial flushing		Bronchospasm	
Hypotension		Vomiting or diarrhoea		Flank pain	
Hypertension		Itching (pruritis)		Dyspnoea	
Tachycardia		Rash (urticaria)		Haematuria	
Other					
Delayed adverse event (>24 hours post transfusion)	Please describe:				

f) Management of Reaction

How was the adverse reaction managed? **(circle)** Analgesia | Antihistamines | Steroids | Diuretics | Other

Please describe: _____

If the patient had dyspnoea, was a chest x-ray performed or was oxygen administered? Please provide details and x-ray findings if applicable:

_____

Was the patient receiving haemodynamic support (ventilator, inotropes, vasopressors)? _____

Was the patient on antibiotics prior to the transfusion? _____

Was the patient receiving colloid intravenous fluids? _____

Did the patient die as a result of the transfusion? **(circle)** Yes | No | Unsure if patient death was related to the transfusion

Reporting Clinician's Details

Name (Please print) _____ Signature _____

Cell Phone Number _____ Date _____

Please contact the WCBS Lead Medical Consultant if you would like to discuss this incident: Dr. Caroline Hilton | caroline@wcbs.org.za | (021) 507-6441

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