University Health System

University Health System
4502 Medical Drive
San Antonio, Texas 78229

Place Patient Label Here

EMERGENCY TRANSFUSION RECORD

MUST *be included in the Patient's Medical Record* ***(Form is not returned to Blood Bank)***

To Be Completed By Blood Bank R – Red Blood Cells F – Fresh Frozen Plasma P – Platelets C - Cryoprecipitate				**To Be Completed by Individual Administering** ***Please reference Nursing Guideline 3.1000***			
	Unit #	**E Code**	**Product Type** ***Circle***	**Verification Signature**		**Transfused** **✓ = *Yes*** **Blank = *No***	**Returned to Blood Bank ✓** **= *Yes*** **Blank = *No***
1.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
2.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
3.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
4.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
5.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
6.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
7.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
8.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
9.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		
10.			R F P C	*Authorized Staff # 1 (initial/time/date)*	*Authorized Staff # 2 (initial/time/date)*		

Emp. ID & Signature/Initial	Emp. ID & Signature/Initial	Emp. ID & Signature/Initial	Emp. ID & Signature/Initial

TO BE PLACED IN MEDICAL RECORD
DOWNTIME FORM

Suspected Transfusion Reaction Notification and Workup Request

1. If you suspect a possible transfusion reaction, STOP THE TRANSFUSION immediately. Keep the intravenous line open (KVO) with a slow infusion of normal saline.
2. Notify the physician & Transfusion Services @ (743-4466) regarding patient management.
3. If localized hives, itching, or flushing are the only manifestations of the reaction, then the physician may order administration of an anti-histamine (e.g. diphenhydramine/Benadryl). If administration of an anti-histamine resolves these symptoms/signs , then you may restart the transfusion, as ordered by the physician. If these symptoms/signs reappear, then stop the transfusion completely, notify Transfusion Services@ (743-4466), and initiate a suspected transfusion reaction (TXRX)workup.
4. Initiate a suspected TXRX workup if the following signs or symptoms occur:
    a. Generalized hives/urticarial, pruritus, flushing
    b. Shortness of Breath/Dyspnea, wheezing, cyanosis
    c. Facial swelling, periorbital edema, perioral edema, stridor
    d. Fever (rise in temperature of 1.0C/2.0F with temperature ≥ 38.2C or 100.6F), chills, shaking or rigors
    e. Back/flank pain, abdominal pain, pain at site of IV insertion, anxiety
    f. Hyper or Hypo tension, chest pain
    g. Nausea/vomiting, headache
    h. Sudden unexplained change in patient condition
5. As part of the workup, document the reaction in the Blood Products Transfusion Note in Sunrise or if during downtime complete the paper nurse flowsheet.
6. Soft IDTX: Stop the transfusion in Soft and document the TXRX in RN observation field in Soft. Draw a pink top tube using SOFT ID and send to the blood bank for a transfusion reaction work up (per protocol).
7. Downtime: A transfusion reaction order (in Sunrise this is POST-1 order set) should be placed in Sunrise by physician or verbal order. Draw a pink top tube labeled with collector's initials, date and time.
8. Secure the unit and administration set. Close tubing securely to prevent contamination. Place in plastic bag.
9. Return the patient sample, discontinued blood bag/infusion set (even if the transfusion is complete) with the copy of the Emergency Transfusion Record if not using Soft ID TX for the transfusion the Transfusion Service.

REPORT OF SUSPECTED TRANSFUSION REACTION

SYMPTOMS **AMOUNT GIVEN** 1/4 1/2 ALL

☐ FEVER OF 2° ABOVE PRETRANSFUSION TEMPERATURE

DID PATIENT EXPERIENCE FEBRILE EPISODES PRIOR TO TRANSFUSION? ☐ YES ☐ NO

☐ CHILLS ☐ HEMOGLOBINURIA ☐ DYSPNEA ☐ FLUSHING ☐ CHEST PAIN

☐ URTICARIA ☐ HYPOTENSION ☐ LOW BACK PAIN ☐ BURNING ALONG INFUSION SITE

☐ OOZING FROM WOUND OR VENIPUNCTURE ☐ OTHER

HAS PATIENT EXPERIENCED SIMILAR SYMPTOMS PRIOR TO TRANSFUSION? ☐ YES ☐ NO

1. **STOP TRANSFUSION IMMEDIATELY, BUT KEEP IV OPEN.**
2. **COMPLETE TABLE**
3. **NOTIFY PATIENT PHYSICIAN**
   NAME/ID _____
   BEEPER # _____
   BY: _____**RN**
4. **TRANSFUSION REACTION INVESTIGATION REQUESTED BY PHYSICIAN** ☐ YES ☐ NO

IF YES:

A) **RETURN THIS FORM AND BLOOD BAG TOGETHER WITH ATTACHED IV SET AND SOLUTIONS TO BLOOD BANK.**

B) **DRAW A PINK TOP TUBE FROM A DIFFERENT SITE THAN THE INFUSION SITE, SEND TO BLOOD BANK.**

C) **COLLECT NEXT URINE SPECIMENT, SEND TO BLOOD BANK.**

RECHECK AT BEDSIDE

FROM PT'S T-BAND

NAME

MRN

T-BAND

FROM FRONT OF COMPONENT TAG

NAME	**UNIT BLOOD TYPE**
MRN	**UNIT #**
T#	**PATIENT BLOOD TYPE**

FROM FRONT OF BLOOD COMPONENT

UNIT #

UNIT BLOOD TYPE

COMMENTS:_____

TO BE PLACED IN MEDICAL RECORD
DOWNTIME FORM