APPENDIX B: 518 BLOOD OR BLOOD COMPONENT TRANSFUSION RECORD

518-123 NSN 7540-00-634-4158

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I - REQUISITION

COMPONENT REQUESTED *(Check one)*
- ☐ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of ______ units)*
- ☐ CRYOPRECIPITATE *(Pool of ______ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* ______

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- ☐ TYPE AND SCREEN
- ☐ CROSSMATCH

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE

DATE REQUESTED

DATE AND HOUR REQUIRED

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* ______ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

DATE VERIFIED

TIME VERIFIED

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO. | TRANSFUSION NO. | PATIENT NO.

TEST INTERPRETATION: ANTIBODY SCREEN | CROSSMATCH

PREVIOUS RECORD CHECK: ☐ RECORD ☐ NO RECORD

SIGNATURE OR PERSON PERFORMING TEST

DONOR | RECIPIENT
ABO | ABO
Rh | Rh

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION
I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION
TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN | TIME/DATE COMPLETED/INTERRUPTED

REACTION ☐ NONE ☐ SUSPECTED | TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION
☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☐ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION – USE EMBOSSER (For typed or written entries give: Name–Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX | WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

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