Report and Investigation of Transfusion Reaction
Department of Clinical Laboratories
The Ohio State University Wexner Medical Center

TO BE COMPLETED BY THE NURSE:

Patient Legal Name

Medical record number

Location

Call back number

Date/time:_____

Signs/symptoms:_____

_____

_____

_____

Started:_____

Stopped:_____

Amount given:

Component:_____

Patient Diagnosis:_____

Physician notified:_____

Date and time Transfusion Service notified:_____

Reported By:_____

Pre-Vitals: Temp:_____ Pulse:_____ Resp:_____ BP:_____

Post-Vitals: Temp:_____ Pulse:_____ Resp:_____ BP:_____

POST- REACTION SPECIMEN INFORMATION

Post-transfusion specimen drawn by:_____ Date/time:_____

Clerical Check*: Armband:_____ Unit Label:_____ Crossmatch label:_____

Donor Number(s):_____

*** Clerical check-Compare the patient's Identification Band to the crossmatch label for full legal name (identical spelling) and Medical Record number. Compare the crossmatch label and component label for Blood Type and RH, unit number, product code, expiration date and time and initials of 2 Blood Bank personnel. Write "OK" in the clerical check fields that are acceptable and "Not OK" in the clerical check fields that are not acceptable.**

FOR LABORATORY USE ONLY
INITIAL BLOOD BANK WORKUP

Clerical Check:	Hemolysis:	Pre:	Post:	DAT:	Pre:	Post:
ABO/Rh Confirmation	Anti-A:	Anti-B:	Anti-D:	A1 cells:	B cells:	Interpretation:
Technologist:	Report given to:			Date/time:		

Other information:

Laboratory impression:

DATE PRINTED: 7/22/19
DO NOT STORE BLANK FORMS. Print current version from QPulse.