CANADIAN BLOOD SERVICES
WINNIPEG CENTRE
777 William Ave, Winnipeg, MB R3E 3R4

TRANSFUSION REACTION INVESTIGATION

PHIN

LAST NAME

FIRST NAME

DOB YYYY-MM-DD

☐ Male

☐ Female

Diagnosis ______________________________

Reason for Transfusion ______________________________

Reaction Date ____________ YYYY-MM-DD **Time** ________ HH:MM

Form Completed By

____
Print Name Classification Initials

Name of Physician/Authorized Health Care Provider Authorizing Investigation:

______________________________ Time ________ HH:MM

Transfusion Reaction Sample Collected at

Facility ______________ Ward/Unit ______________

History

Transfusions ☐ Yes <3 mo. ☐ Yes >3 mo. ☐ No ☐ Unknown

Preg. Miscarriages ☐ Yes <3 mo. ☐ Yes >3 mo. ☐ No ☐ Unknown

Immune Compromised ☐ Yes ☐ No ☐ Unknown

Phlebotomist

____
Print Name Classification Initials

Collection Date ____________ YYYY-MM-DD Time ________ HH:MM

Premedication (i.e. antipyretics, antihistamines, etc.) ☐ No ☐ Yes

If Yes, Specify Drug(s): ______________________________

Pre Transfusion Hemoglobin ______________ g/L

Transfused Under Anesthesia: ☐ No ☐ Yes ☐ General ☐ Local

Vital Signs

PRE Temp ______ Pulse ______ BP ______ O_2 Sat ______

POST Temp ______ Pulse ______ BP ______ O_2 Sat ______

NEW ONSET Clinical Signs and Symptoms

☐ Chills/Rigors ☐ Hemorrhage ☐ Jaundice ☐ Shortness of Breath

☐ Urticaria ☐ Hemoglobinuria ☐ Oliguria ☐ Tachycardia/Arrythmia

☐ Pruritus ☐ Hypertension ☐ Severe Allergic Reaction ☐ Headache

☐ Other Skin Rash ☐ Hypotension ☐ Severe Respiratory Distress ☐ Pain: Specify ______________

☐ Nausea/Vomiting ☐ Hypoxemia ☐ Shock ☐ Other ______________

Reaction Type:

☐ Minor

☐ Major

Measures Taken ☐ None Required

☐ Analgesics ☐ Chest X-Ray ☐ Steroids ☐ Transfusion Stopped

☐ Antibiotics ☐ Diuretics ☐ Supplementary O2 ☐ Transfusion Restarted

☐ Antihistamines ☐ ICU Required ☐ Vasopressors ☐ Patient Blood Culture Ordered

☐ Antipyretics ☐ Mechanical Ventilation ☐ Other, Specify: ______________ ☐ Component Blood Culture Ordered

Blood Component Transfusion Reaction (E.g. Red Cells, Plasma, Platelets, Cryo)

Donor ABO/Rh	Product Type	Donation Number	Volume Given (mL)	Date/Time Started (YYYY-MM-DD HH:MM)	Date/Time Finished (YYYY-MM-DD HH:MM)	Expiry Date (YYYY-MM-DD)	Product Code #	Product Modifiers

Derivative Transfusion Reaction (E.g. Albumin, IVIG, Factor Concentrates)

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV / IM)	Frequency	Time Started (HH:MM)	Time Finished (HH:MM)	Expiry Date (YYYY-MM-DD)

Nursing Clerical Check

Nurse 1 Print Name ______________ Date/Time (YYYY-MM-DD HH:MM) ______________

Nurse 2 Print Name ______________ Discrepancies ☐ No ☐ Yes If Yes, Specify ______________

Facility Blood Bank Clerical Check ☐ Component(s) Sent for Culture

Print Name ______________ Date/Time ______________ Discrepancies ☐ No ☐ Yes If Yes, Specify ______________

Date / Time Received at Facility Blood Bank	Sample Accession Label	Sample / Req Comparison
Date / Time Received at Centre		Accessioned