LifeStream
GIVE HOPE | GIVE LIFE | GIVE BLOOD

TRANSFUSION REACTION FORM

Transfusing Facility: _____ Date of Transfusion: _____

Patient Name: _____ DOB: _____
(Last Name) (First Name) (Middle Name)

Patient M.R.N.: _____ _____

Blood Component Transfused: _____

Unit #: _____

Symptoms	Immediate	Delayed		Symptoms	Immediate	Delayed
Elevated Temperature				Pain		
Change in BP				Rash		
Restlessness				Pruritus		
Chills				Shock		
Delirium				Jaundice		
Dyspnea				Petechiae		
Nausea/Vomiting				Hematuria		

Other (describe): _____

If Transfusion Reaction Occurred

- ☐ Stop transfusion immediately.
- ☐ Full Unit Transfused
- ☐ Portion Transfused Time stopped: _____ Amount Transfused: _____
- ☐ Notify patient's physician. Date: _____ Time: _____
- ☐ Notify LifeStream (Phone: 909-386-6858). Date: _____ Time: _____
- ☐ Check for clerical error.
- ☐ If indicated, draw post-transfusion specimens immediately (two 6 mL EDTA).
  Label tubes "Post-Transfusion Specimen."
  Post-Transfusion Sample Drawn: Date: _____ Time: _____ By: _____
- ☐ Complete and return a copy of this form, Transfusion Record, the post-transfusion specimens, infusion set, and the blood bag to LifeStream immediately.
- ☐ Follow your protocol for transfusion reaction investigation (e.g. collect urine samples, check hemoglobin).
- ☐ If indicated, arrange for emergency medical transportation to the acute care facility.
- ☐ Medications or Treatment: _____

FOR REFERENCE LABORATORY USE ONLY
Notify LifeStream Medical Director
Comments:

Called to: _____ Name/Date/Time: _____

_____
Date/Initials

Retain original Transfusion Reaction Form at Transfusing Facility
Provide a copy of Transfusion Reaction Form to LifeStream