REQUEST FORM FOR TRANSFUSION REACTION INVESTIGATION (BLOOD AND BLOOD COMPONENTS)

1. When a patient has an adverse reaction to any blood or blood component, **STOP** transfusion immediately. **URGENTLY** inform the doctor in charge of the patient and the Blood Bank.

2. Report all reactions and do the following:

   2.1 Preserve the blood bag and giving set with all attached labels. Seal it securely and send immediately to the Blood Bank.

   2.2 Send the following samples for transfusion reaction investigation to the Blood Bank or relevant laboratory.

   a. Post-transfusion sample 1 (immediately)
      I. 10 mls of blood in EDTA bottle
      II. 10 mls of urine for haemoglobinuria

   b. Post-transfusion sample II (after 24 hours)
      I. 10 mls of blood in EDTA bottle
      II. 10 mls of urine for haemoglobinuria

   2.3 Please send for other appropriate investigations if necessary.

   2.4 Please refer to Section 10: Adverse effect of transfusion in Handbook on Clinical Use of Blood for details.

Hospital: ……..... Ward/Clinic: ……

Patient's name: …… IC/Passport No: ……..……..

Race: ……..…….. Age: ……..… Sex: ……..…..

Diagnosis……...

i. Date and time transfusion started ……...

ii. Date and time of onset of reaction ……....

iii. Blood/ Blood Component Serial No. ……

iv. Volume Blood/ Blood Component transfused ……

v. Blood Pressure: Before transfusion …… After transfusion …….

vi. Temperature: Before transfusion …… After transfusion …….

vii. Nature of Reaction: Tick off **(√)** the positive symptoms/signs.

Fever	☐	Shock	☐	Haematuria	☐
Chills /Rigors	☐	Jaundice	☐	Haemoglobinuria	☐
Urticaria	☐	Dyspnoea	☐		
Pain	☐	(Location of pain if present.....……)			

viii. Solution used for starting IV drip: - N.Saline / 5% Dextrose / Others ……

ix. History of previous transfusion: Yes / No

Date of last transfusion: ……..

x. History of previous transfusion reaction if any:

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xi. Medication (If any, please specify):

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xii. Applicable for female patients ONLY:

History of pregnancy: Yes / No No. of pregnancies: ……

History of abortion: Yes / No No. of abortions: …….....

xiii. History of transplant: …….

Date of transplant: ……..

Date: …… Signature: ……..

Name: ……..……

PLEASE SEND THIS FORM TO THE BLOOD BANK WITH ALL REQUIRED SAMPLES FOR INVESTIGATION