NSW GOVERNMENT Health
Northern NSW
Local Health District

Facility: _____

NOTIFICATION OF ADVERSE TRANSFUSION REACTION

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Please complete form and forward copy to transfusion service (fax numbers are below). Retain original in patient notes

Tweed Transfusion Service: 07 5506 7822
Lismore Transfusion Service: 02 6620 2917
Grafton Transfusion Service: 02 6640 2466

Copy sent to: ..... **Date:** / /

Product type and donation/batch number	**Transfusion details**
Red cells	Date of transfusion ..... / ..... / .....
Platelets	Time product commenced (24 hrs) ..... : .....
Fresh frozen plasma	Time reaction started ..... : .....
Albumin	Amount transfused ¼ ½ > ½
Immunoglobulin	.....
Other (specify)	.....
. .....	.....

TRANSFUSION REACTION DETAILS

Baseline vital signs		**Peak/trough vital signs**	
Temp ..... °C	BP..... mmHg	Temp ..... °C	BP..... mmHg
Resp. rate ..... /min	Heart rate..... /min	Resp. rate ..... /min	Heart rate..... /min

OTHER SIGNS AND SYMPTOMS

Respiratory:	☐ wheeze	☐ tachypnoea	☐ dyspnoea	☐ stridor	☐ pulmonary oedema
Skin:	☐ urticaria: isolated	☐ extensive	☐ rash: macular	other	
Systemic:	☐ facial oedema	☐ other oedema	☐ anaphylaxis		
CNS:	☐ LOC	☐ anxiety	☐ confusion		
Pain:	☐ VAD site	☐ infusion arm	☐ back/loin pain	other	
Bleeding:	☐ VAD site	☐ skin (purpura)	☐ haematuria	other	

Comments and further description .....
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Management and interventions .....
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☐ All bags and giving set returned ☐ 9 mL EDTA sample and request form to Transfusion service
Please ensure form and specimen meets labelling requirements, complete collector declaration

☐ Check label and pt ID ☐ FBC ☐ Coags ☐ Biochem ☐ Blood gas ☐ Urine ☐ Blood cultures ☐ IIMs

☐ Other .....

Name ..... Position .....

Signature ..... Contact number ..... Date / /

BINDING MARGIN – NO WRITING

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NO WRITING OUTSIDE BORDER

Document Control: Author: NNSW LHD Clinical Quality Manager, V1, Aug. 2013.