Ward Patient Transfusion Reaction Report Form

In the event of an adverse reaction following transfusion of blood or blood components, fill out this form and send to the **Hospital Blood Bank** and **ZAMRA** (Email: npvu@zamra.co.zm; or WhatsApp: **+260 956 521094**).

PATIENT INFORMATION		
Initials:	Date of Birth: dd/mm/yyyy	Age:
Sex: ☐ Male; ☐ Female	Blood Group:	
Hospital:	Ward:	
Patient File No.:	Blood Bank No.:	
Primary Diagnosis:		
Indication for Transfusion:		
Concurrent Medication:		

TRANSFUSION REACTION DETAILS		
Start of reaction: **Date:** dd/mm/yyyy **Time:** hh/mm	**End of reaction:** **Date:** dd/mm/yyyy **Time:** hh/mm	**Ongoing** ☐

Type of reaction: ☐ Non-serious ☐ Serious

Reason for Serious: ☐ Death ☐ Life-threatening ☐ Disabling or incapacitating ☐ Hospitalisation ☐ Congenital anomaly or birth defect ☐ Other (Specify): ……

Transfusion details:

Product Transfused	Pack Number	Expiry date	Blood Group	Date & Time Transfused		Product Warmed?	Transfusion Duration	Volume Transfused
				dd/mm/yyyy	hh/mm			
				dd/mm/yyyy	hh/mm			
				dd/mm/yyyy	hh/mm			
				dd/mm/yyyy	hh/mm			

Patient`s vitals:

Pre-transfusion Vitals	Temp:	BP:	Pulse:	RR:	Sats:	Hb:
Post-transfusion Vitals	Temp:	BP:	Pulse:	RR:	Sats:	Hb:

Clinical Signs and Symptoms (tick as may apply)

- ☐ Chills/Rigors
- ☐ Pyrexia: _____ °C
- ☐ Nausea
- ☐ Vomiting
- ☐ Pruritus
- ☐ Rash
- ☐ Urticaria
- ☐ Dyspnoea
- ☐ Headache
- ☐ Chest pain/Tight chest
- ☐ Restlessness
- ☐ Attack of sweating
- ☐ Bradycardia
- ☐ Tachycardia
- ☐ Jaundice
- ☐ Dark urine
- ☐ Oliguria
- ☐ Purpura
- ☐ Anxiety
- ☐ Vertigo
- ☐ Collapse/shock
- ☐ Back/flank pain
- ☐ Palpitations (pulse: _____ bpm)
- ☐ Hypotension (BP: _____ mmHg)
- ☐ Hypertension (BP: _____ mmHg)
- ☐ Unexplained bleeding
- ☐ Other:_____
- ☐ Other:_____

Suspected diagnosis

- ☐ Haemolytic reaction
- ☐ Allergic reaction
- ☐ Febrile reaction
- ☐ Bacterial reaction
- ☐ Viral transmission
- ☐ TRALI
- ☐ Transfusion-related dyspnoea
- ☐ Hypervolaemia (TACO)
- ☐ Post-transfusion purpura (PTP)
- ☐ Graft-versus-Host disease
- ☐ Other: _____

Patient Outcome: (Could be filled in later)

☐ Recovered ☐ Recovered with complication	☐ Not yet recovered ☐ Unknown	☐ Died **Date:** dd/mm/yyy **Time:** hh/mm

Details of The Reporter:

Reporter`s Name:	Signature:	Date: dd/mm/yyy
Contact No.:	E-mail:	