

Blood Transfusion Record

Patient Name (Print)	DOB
Patient ID	Date
Transferring Hospital Name	Receiving Hospital Name

PRE-TRANSPORT IDENTIFICATION:

- Patient wristband ID compared with ALL blood component units at patient's bedside with hospital staff
- Products are packed in a validated transport container, with a pre-transfusion blood specimen if available
- Number and type of components agrees with physician's orders
- Patient has a dedicated venous access line with only blood and/or 0.9% NaCl running

Hospital Staff (MD or RN): _____
PRINT NAME SIGNATURE

EMT-CC/P: _____
PRINT NAME SIGNATURE

Ambulance Service: _____
PRINT NAME

Vital signs, including patient temperature, are to be monitored every 10 minutes and recorded on PCR.

COMPONENTS TRANFUSED:

Component	Unit ID Code	Unit ABO/Rh	Start Date/Time	End Date/Time	Adverse Reaction (Record details on PCR)
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO

If acute transfusion reaction is suspected: stop infusion, replace all tubing and maintain IV line with 0.9% NaCl. Contact Medical Control ASAP. Treat per protocol. Remainder of unit and administration set must be given to receiving hospital staff. Do not initiate another unit unless advised to do so by Medical Control.

Medical Control Contacted: _____
PRINT NAME SIGNATURE

Was a transfusion reaction suspected? Check correct box below.

- No - Transfusion Reaction NOT Suspected (Check off each item as completed.)**
- Discard empty blood bags & used administration sets as medical waste. Give the following to receiving hospital staff for delivery to blood bank:
 - Transport container(s) Unused blood component(s) Blood specimen(s) (if any)
 - Manifest/Packing slip Copy of Blood Transfusion Record
- Yes - Transfusion Reaction Suspected (Check off each item as completed.)**
- Give the following to receiving hospital staff for delivery to blood bank:
- Transport container(s) All blood bags Used administration sets Blood specimens (if any)
 - Manifest/Packing slip Blood Transfusion Record Pre-Hospital Care Report

Receiving Hospital Staff: _____
PRINT NAME SIGNATURE

TITLE DATE TIME

Copy to – Receiving Hospital Blood Bank
 Copy to– Ambulance Transfusion Service
 Copy to – fax to Issuing Hospital Emergency Room after completed