COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL CENTER

Patient Label

Tranfusion Reaction Form (NUR-006B)

Retain Original Copy in Medical Record; Send Copy to Lab

1. Patient and Blood Product Unique Identification Verification

Is the information IDENTICAL on all the following:

●Patient ID band ●Transfusion Record/Compatibility Tag ●Blood Product Label □ Yes □ No

If no, explain:

2. Clinical History (Check all that apply)

□ Pre-existing fever	□ History or evidence of circulatory overload
□ Transfusion pre-medication Specify:	
□ Immune-compromised Specify:	□ Antibiotic Specify:

□ History of Transfusion: □ Yes □ No □ Unknown □ Within 3 months □ Greater than 3 months

□ History of Previous Transfusion Reaction: □ Yes □ No Date (if known):

3. Location, Date & Time of Transfusion Reaction

Patient location: □ Med/Surg □ ER □ Outpatient

Date of Transfusion:	Time Transfusion Started:
Time Reaction Occurred:	Time Transfusion Stopped:
Time Transfusion Restarted:	

4. Clinical Signs & Symptoms

Vital Signs	Temp	Pulse	RR	BP	O2 Sat	Room Air	Supplementary O2
Pre-transfusion							O2 @ _____LPM
Post-transfusion							

□ Hives	□ Chills	□ Restlessness	□ Chest Pain	□ Diffuse Hemorrhage
□ Itching	□ Rigors	□ Anxiety	□ Heat/Pain @ IV site	□ Facial Swelling
□ Skin rash	□ Flushing	□ Nausea/Vomiting	□ Jaundice	□ Tongue Swelling
□ Hypertension	□ Hypotension	□ Tachycardia	□ Shock	□ Shortness of Breath
□ Fever:	□ Headache	□ Joint/Muscle Pain	□ Red or Brown Urine	□ Wheezing
Oral T > 100.4°F or higher AND 1.8°F or more rise above baseline	□ Dizziness	□ Back Pain	□ Oliguria	□ Hypoxemia
	□ Other:			

5. Blood Product(s) & Equipment Information

Blood Product Type	Unit Number	Volume Transfused (total # of ml)	

Filters/Equipment Used: □ Standard Blood Filter □ IV Pump □ Blood Warmer □ Rapid Infusion Device

□ Other:

6. Measures & Notifications

□ Antipyretics	□ Vasopressors	□ Blood Samples
□ Antihistamines	□ Analgesics	□ Urine Sample
□ Steroids	□ Supplementary O2	□ IV tubing changed & KVO with NS
□ Diuretics	□ Chest X-ray	□ Blood Bag & Tubing Saved for Blood Bank
□ Antibiotics	□ Ventilation	

□ Blood Bank Notified Date: _____ Time: _____ By: _____

Name of Physician/Provider Notified: _____ Date: _____ Time: _____

Report Completed By: _____ Date: _____ Time: _____