COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Blood Transfusion Administration Form (NUR-006C)

Patient Name: _____ Date: _____/_____/_____

Verification Section **To Be Completed by RN and Second Licensed Nurse** **All Safety Checks Must Be Verified By Both Nurses Together Prior to Administration of Blood Product** ***Involve patient in identification process*** ***See Back for Patient Monitoring Flowsheet***					
Safety Check Indicators	**Verified By (Initials)**	**Verified By (Initials)**	**Safety Check Indicators**	**Verified By (Initials)**	**Verified By (Initials)**
Patient Name			Blood ID Patient Wristband & Blood ID on Unit Match		
Second Patient Identifier Checked (DOB, MR#)			Blood Type		
Physician Order			Expiration Date Checked & Within Range		
Patient Consent Completed			Blood Bag Unit Number & Unit Number on Lab Slip Match		
Nurse Name & Title:					
Nurse Name & Title:					

Place & Secure Blood Requisition Here

Patient Sticker

Blood Administration
Patient Monitoring

Patient Name: _____ Date: _____/_____/_____

Type of Blood Product: □ RBC □ LRBC □ Platelets □ FFP □ Irradiated Blood □ CMV negative

Time & Date Unit Received from Lab: _____:_____ _____/_____/_____ Unit Number: _____

Type & Gauge of Venous Access Device: _____

Infusion Device Used: _____ Flow Rate: _____ IVF used to Prime & Flush Line: _____

Transfusion Initiated By (Print Name & Title): _____

Vital Signs	Time	Temp	Pulse	Resp	Blood Pressure	O2 Sat	Nurse Initials & Title
Pre-Transfusion							
Start of Transfusion							
15 minutes after initiation of transfusion							
Every 15 minutes x1 hour							
Every 15 minutes							
Every 15 minutes							
Every 15 minutes							
Every 30 minutes for remainder of transfusion							
Every 30 minutes							
Every 30 minutes							
Every 30 minutes							
Every 30 minutes							
Every 30 minutes							
Transfusion Completed/Stopped Time: _____:_____ Date: _____/_____/_____							
One Hour Post-Transfusion							

	NOTES

Signature of Nurse (RN): _____ Initials: _____ Date: _____/_____/_____

Signature of Nurse (RN/LPN): _____ Initials: _____ Date: _____/_____/_____

Signature of Nurse (RN/LPN): _____ Initials: _____ Date: _____/_____/_____

Patient Sticker