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Blood Transfusion Record

Patient's Label

Patient Name: _____

IP No._____ UHID No. _____

Age/Gender _____

Name of the Consultant: _____

Date of Admission: _____

PRE-TRANSFUSION CHECKLIST

1. Is informed consent available: ☐ Yes ☐ No
2. Is there any previous history of transfusion related adverse event: ☐ Yes ☐ No
3. Have the relatives been informed about transfusion: ☐ Yes ☐ No
4. Whether Compatibility sticker of blood bag checked: ☐ Yes ☐ No

SAFETY PAUSE: (To be filled by In charge/Shift Incharge) To be verified for each unit

Verified by	Nurse	Doctor
• Name • UHID • Blood Group • Date of Expiry • Any visible deterioration in blood bag (change of color or any clumping)		

Verified by Nurse: Name _____ Emp. ID _____ Sign _____
Verified by Doctor: Name _____ Emp. ID _____ Sign _____

TRANSFUSION INSTRUCTIONS:

- Start transfusion within 30 minutes of issuance from the blood bank.
- Use a fresh, clean, sterile, pyrogen free transfusion set with a filter for all transfusions.

- Complete the transfusion within prescribed time for each unit (PRC- 4 hours, FFP- 1hr, Cyro – 30 mins, RDP- 30 mins, SDP- 1hr)
- Start at a slow rate (5 drops/min for 1st five minutes) for the first half an hour and monitor strictly for a reaction.
- Monitor the vitals every 15 min for the first half an hour and then every half an hour until completion
- Please do not add any medication to the blood component or in the same line.
- In case of any transfusion related complication, follow part B of this form.

Part A: TRANSFUSION RECORD

Whether pre-medication given: yes / no
If yes, mention medicine given with dose & route: _____

Component Type		Blood Bag Number	Bag's Date of Expiry	Group & Type	Starting Date & Time	Ending Date & Time	Administering Staff Nurse		Counter-checking By Doctor		Any reaction Yes/No
							Name	Sign	Name	Sign	
Vitals Duration		1st Vital	After 15 min	30 min	60 min	90 min	120 min	150 min	180 min	210 min	Ending Time
Vitals	Time										
	Temp										
	Pulse										
	B.P.										
	R.R.										
	SpO2										

Part B: TRANSFUSION REACTION RECORD (To be completed by Doctor)

Identify and document, the recognized symptoms:		
Fever (more than 1 degree rise of temperature as compared to pre transfusion vitals) ☐ Allergic ☐ Rigors & Chills ☐ Urticaria ☐ Hypotension ☐ Hypertension ☐	Bradycardia < 40/min ☐ Tachycardia> 100/min ☐ Chest Pain ☐ Back pain ☐	Dyspnea ☐ Desaturation < 90% ☐ Oliguria/ anuria ☐ Hematuria ☐
Type of transfusion reaction: Febrile/Allergic/ Urticarial/Anaphylaxis/Hemolytic reaction **IDENTIFIED BY:** Name/Signature (Doctor) _____ Date/ Time _____		

SUGGESTED MANAGEMENT:

1. Stop transfusion.
2. Keep the IV line open with normal saline.
3. Inform the attending physician and the blood bank.
4. Recheck all the labels and terms for the correct identity of the patient and the blood units.
5. Send the following to the blood bank:
   - Immediate post transfusion plain and EDTA blood sample.
   - Blood bag along with the BT set.
   - First urine sample to be sent to the lab for R/E.
   - Samples sent: Yes/ No
6. Treatment given:

_____
_____
_____

Paste the transfusion Label	**Paste the transfusion Label**

HAEMOVIGILANCE PROGRAMME OF INDIA

Transfusion Reaction Reporting Form (TRRF) For Blood & Blood Components & Plasma Products (Version-2)					
					*** Mandatory Field**
(A) Patient Information					
Hospital Code No.:					
Patient Initials*:	Gender*:		Blood Group*:		
Hospital Admission No.*:	Age/Date of Birth*:				
Primary Diagnosis*:					
Medical History:					
(B) Transfusion Reaction Details*					
Was the patient under anaesthesia during transfusion: Yes/No if Yes type: GA/Spinal/LA					
Pre-transfusion Vitals:	Temp:	Pulse:	BP:	RR:	SPO_2:
Vitals at the time of reaction:	Temp:	Pulse:	BP:	RR:	SPO_2:
Please tick mark the relevant signs and symptoms listed below					
Generalised		**Pain**	**Respiratory**	**Renal**	**Circulatory**
☐ Fever	☐ Anxiety	☐ Chest Pain	☐ Dyspnoea	☐ Haematuria	☐ Tachycardia
☐ Chills	☐ Itching (Pruritus)	☐ Abdominal	☐ Wheeze	☐ Haemoglobinuria	☐ Hypertension
☐ Rigors	☐ Edema (Site)_____	☐ Back/Flank Pain	☐ Cough	☐ Oliguria	☐ Hypotension
☐ Nausea	☐ Jaundice	☐ Infusion Site Pain	☐ Hypoxemia	☐ Other_____	☐ Arrhythmias
☐ Urticaria	☐ Other_____	☐ Other_____	☐ Bilateral Infiltrates on Chest X-ray		☐ Other_____
☐ Flushing			☐ Other_____		

☐ Restlessness					
☐ Vomiting					
Any Other (Specify):					

(C) Transfusion Product(s) Details*

Transfusion Product(s) Details	Select	Component	Indication	Date & Time of Issue of Blood Component	Date & Time of Onset Transfusion	Unit ID (Transfused)	Blood Group	Volume Transfused (ml)	Expiry Date of Blood Component	Manufacturer of Blood Bag	Batch/Lot No. of the Blood Bag	1st Time/Repeat Transfusion
☐	Saline Washed Red Cells											☐ 1st Time ☐ Repeat 1 to 10 ☐ Repeat > 10
☐	COVID-19 Convalescent Plasma											
☐	Whole blood											
☐	Packed Red blood cells (PRBC)											
☐	Buffy coat depleted PRBC											
☐	Leukofilter PRBC											
☐	Random Donor platelets/ pooled											
☐	Apheresis Platelets											

☐	Fresh Frozen Plasma											
☐	Cryoprecipi -tate											
☐	Any Other											

Add New Plasma Product

Select	Plasma Product	Indication	Date of Administration	Manufacturer	Expiry Date of the Plasma Product	Batch No./Lot No.	Ist Time / Repeat
							☐ Ist Time ☐ Repeat 1 to 10 ☐ Repeat > 10

(D) Investigations

☐	**Clerical Checks**	**Specify Error Found if any: _____**

Investigation		**Pre-transfusion sample**	**Pre-transfusion sample**
☐	Visual Check		
* ☐	Repeat Blood Grouping	O+ /A+ /B+ /AB+ /O- /A- /B- /AB-	O+ /A+ /B+ /AB+ /O- /A- /B- /AB-
* ☐	Repeat Crossmatch	☐ Compatible ☐ In-Compatible ☐ Not Done	☐ Compatible ☐ In-Compatible ☐ Not Done
* ☐	Repeat Antibody screen	☐ Negative ☐ Positive ☐ Not Done	☐ Negative ☐ Positive ☐ Not Done
☐	Antibody Identification		
* ☐	Direct antiglobulin test	☐ Negative ☐ Positive	☐ Negative ☐ Positive

		☐ Not Done	☐ Not Done
☐	Haemoglobin		
☐	Urine haemoglobin		
☐	Bilirubin (Total/conjugated)		
☐	Platelet count		
☐	PT/INR		
* ☐	Blood culture of Blood Bag	☐ Negative ☐ Positive ☐ Not Done ☐ Specify Organism if positive_____	
* ☐	Blood culture of patient	☐ Negative ☐ Positive ☐ Not Done ☐ Specify Organism if positive_____	☐ Negative ☐ Positive ☐ Not Done ☐ Specify Organism if positive_____
☐	Chest X-ray of the patient in case of suspected TRALI		
In case of non-immune hemolysis (which of the following was the case?)			
☐	Hemolysis due to freezing of PRBC Units		
☐	Hemolysis due to inappropriate warming of PRBC Units		
☐	Hemolysis due to infusion of any other fluid through the same BT set.	Specify Fluid: _____	
☐	Mechanical damage		
In Case of ABO Mismatch (which of the following was the case?)			
☐	Wrong Blood in tube		
☐	Grouping error		
☐	Labelling error		
☐	Wrong unit transfused		
(E) Nature of Adverse Reaction(s)*			

Select	Reaction	Date & Time of Onset of Reaction	Date & Time of Recovery	Outcome
☐	Febrile Non-Haemolytic Reactions (FNHTR) 1° C rise in temperature ☐ 2° C rise in temperature ☐ Only Chills & Rigors ☐			☐ 1.Death following the Adverse Reaction(s) ☐ 2. Recovered ☐ 3. Recovered with Sequelae ☐ 4. Unknown
☐	Allergic reaction			
☐	Anaphylaxis			
☐	Immunological Haemolysis due to ABO Incompatibility			
☐	Immunological Haemolysis due to other Allo-Antibodies			
☐	Non-Immunological Haemolysis			
☐	Hypotensive Transfusion Reaction			
☐	Transfusion Related Acute Lung Injury (TRALI) Definite ☐ Possible ☐			
☐	Transfusion Associated Dyspnoea (TAD)			
☐	Transfusion Associated Circulatory Overload (TACO)			
☐	Transfusion Transmitted Bacterial Infection			
☐	Transfusion Transmitted Parasitic Infection (Malaria)			
☐	Post Transfusion Purpura			
☐	Transfusion Associated Graft versus Host Disease (TAGvHD)			

☐	Other Reaction (s)			

IMPUTABILITY ASSESSMENT			
(F) Imputability Assessment*			
S. No.	Reaction Term	Transfusion Product/ Component	*Imputability Assessment (Please mention from the below list)
*Imputability: 1. Definite (Certain), 2. Probable (Likely), 3. Possible, 4. Unlikely (Doubtful), 5. Excluded, 6. Not Assessed			

Monthly Denominator Reporting Form *	
Hospital Code:	**Month/Year:**
Blood Component	**No. of Units Issued**
1) Saline Washed Red Cells	
2) COVID-19 Convalescent Plasma	
3)Fresh Frozen Plasma	
4) Whole Blood	
5) Packed Red Blood Cells (PRBC)	
6) Buffy Coat Depleted PRBC	
7) Leuco Filtered PRBC	
8) Random Donor Platelets/ Pooled	
9) Apheresis Platelets	
10) Cryoprecipitate	
11) Any Other_____	