When a Transfusion Reaction is Suspected:
1. Stop blood transfusion immediately.
2. Summon Physician to attend patient; Call the Blood Bank immediately.
3. Complete form and submit to the Blood Bank:
   a. Properly labeled new Typenex blood specimens - one 7 ml. red top tube and one purple top EDTA tube. (Affix one new Typenex sticker to purple top.)
   b. Properly labeled urine sample - first void after suspected reaction, when available.
   c. Untransfused portion of blood component unit(s) with recipient set, attached IV solutions, this form, and old Typenex band stapled to form.
   d. Old Typenex armband (removal must be witnessed by two individuals and both must sign below).
   e. Pink copy of Confidential Medication Variance Report (NMR 0003).

PATIENT HISTORY
1. Current diagnosis: ________________________________________________________________________
2. Previous transfusion: ☐ Yes ☐ No ☐ Don't Know
3. Any pregnancies: ☐ Yes ☐ No ☐ Don't Know
4. Has patient received IV therapy or IV medications this admission. ☐ Yes ☐ No
   If yes, please list: ________________________________________________________________________

CLINICAL SIGNS/SYMPTOMS (Please check if observed or reported)
☐ chills
☐ headache
☐ pain (specify) ______
☐ nausea/vomiting
☐ hives/rash
☐ facial edema
☐ itching
☐ increased B/P
☐ decreased B/P
☐ fainting
☐ increased pulse rate
☐ rapid temp. increase
☐ wheezing
☐ dyspnea
☐ cyanosis
☐ coughing
☐ oozing from wound
☐ dark/bloody urine
☐ other

PRE AND POST TRANSFUSION VITAL SIGNS

<table>
<thead>
<tr>
<th>TIME</th>
<th>TEMP</th>
<th>B/P</th>
<th>PULSE</th>
<th>RESP</th>
<th>O2 SAT*</th>
<th>TAKEN BY</th>
</tr>
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<tbody>
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TRANSFUSION DETAILS

<table>
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<tr>
<th>Unit #</th>
<th>Date</th>
<th>Time</th>
<th>By</th>
<th>Unit #</th>
<th>Date</th>
<th>Time</th>
<th>By</th>
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</thead>
<tbody>
<tr>
<td>Component Started</td>
<td>Component Started</td>
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<tr>
<td>Amt Transfused Stopped</td>
<td>Amt Transfused Stopped</td>
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PATIENT VERIFICATION - TO BE PERFORMED AT BEDSIDE BY R.N. OR M.D.

Old Typenex band is present on patient ☐ Yes ☐ No Printed Name: ______________________

Pt name and hospital number on Transfusion Report form (MR 000001) matches:
Pt name & hospital number on Typenex armband ☐ Yes ☐ No Printed Name: ______________________
Pt name & hospital number on hospital armband ☐ Yes ☐ No Printed Name: ______________________

Old Typenex armband (#______________________) Date/Time/Location of Band Removal: ______________________

Removed By - Signature: ______________________ Printed Name: ______________________
Witnessed By - Signature: ______________________ Printed Name: ______________________

Post-transfusion Typenex Specimen Collected By: ______________________ Date/Time: ______________________
Post-transfusion Typenex Specimen Verified By: ______________________ Date/Time: ______________________
MD/Nurse/CCP: ______________________ Beeper: ______________________ Date/Time: ______________________