|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Instructions:**  Please complete sections A, B and C.   * Transfusion transmitted diseases will be reported to the blood supplier. * **Document** the symptoms and transfusion history. * Include obstetrical history, if applicable. * Fax this form back to the hospital transfusion service.   Reported by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please print  Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Section A**  **Recipient Demographic Information (please print)**  **Family name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Given name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Middle name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Day/month/year  **PHN: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_** | |
| Section B: Recipient Transfusion History  Please list all dates and locations of transfusion with most recent transfusion first (if multiple apply, please append additional pages):   |  |  |  | | --- | --- | --- | | Date | Product | Location | |  |  |  | | | | **Section C:**  **Signs and symptoms that may be associated with delayed reactions:**   * Weakness * Unexplained fall in hemoglobin; elevated serum bilirubin * Erythroderma, diarrhea, maculopapular rash, pancytopenia * Purpura, bleeding, fall in platelets 8-10 days post-transfusion * Tolerance induction, post-surgical wound infection * Cardiomyopathy, arrhythmia, hepatic/pancreatic failure * Transmissible disease marker positive. Specify | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Section D: Laboratory Investigation** (refer to RT.012 – Investigation of Transfusion Complications) | | | | |
| RBC Antibody Investigation  (if applicable) | Results | | Interpretation: Transfusion Service Medical Director or designate:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Subsequent Transfusion Requirements:**  Subsequent transfusions should be with RBC negative for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ antigens.  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Note:** Compatible blood may not be available in an emergency situation. | |
| Antibodies Identified |  | |
| Most probable genotype |  | |
| Direct Antiglobulin Test (DAT) |  | |
| Other |  | |
| Technologist |  | |
| Date |  | |
| Other comments: | | | | |
| **Section E**: | | | | |
| **Notification of Blood Supplier:** | | Supplier notified? ❒Yes ❒No  Traceback initiated? ❒Yes ❒No ❒Not Applicable  Date notified, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

Copy must be retained on patient’s medical record indefinitely