|  |  |
| --- | --- |
| **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 printPhone 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 HistoryPlease 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