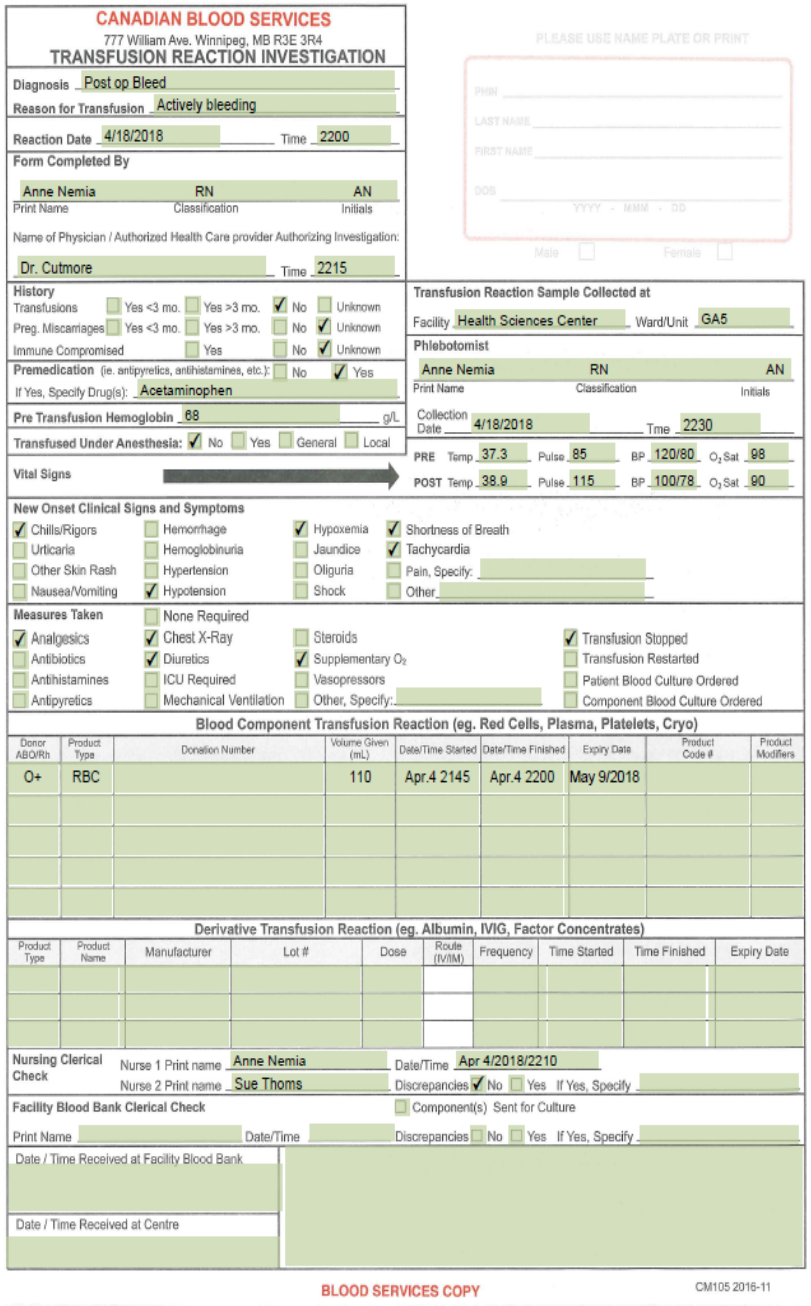
Put what patients current diagnosis is.

Name of physician who is ordering transfusion reaction investigation. This is the physician that is currently taking care of patient in the moment.

Take note of pre medication.

This is the space where the 2 authorized practitioners sign after re doing the 2 person check.



CANADIAN BLOOD SERVICES
777 William Ave. Winnipeg, MB R3E 3R4
TRANSFUSION REACTION INVESTIGATION

Diagnosis: Post op Bleed
Reason for Transfusion: Actively bleeding
Reaction Date: 4/18/2018 Time: 2200

Form Completed By
Anne Nemia | RN | AN
Print Name | Classification | Initials

Name of Physician / Authorized Health Care provider Authorizing Investigation:
Dr. Cutmore Time: 2215

History
Transfusions: ☐ Yes <3 mo. ☐ Yes >3 mo. ☑ No ☐ Unknown
Preg. Miscarriages: ☐ Yes <3 mo. ☐ Yes >3 mo. ☐ No ☑ Unknown
Immune Compromised: ☐ Yes ☐ No ☑ Unknown

Premedication (ie. antipyretics, antihistamines, etc.): ☐ No ☑ Yes
If Yes, Specify Drug(s): Acetaminophen

Pre Transfusion Hemoglobin: 68 g/L

Transfused Under Anesthesia: ☑ No ☐ Yes ☐ General ☐ Local

Vital Signs
PRE Temp 37.3 Pulse 85 BP 120/80 O_2 Sat 98
POST Temp 38.9 Pulse 115 BP 100/78 O_2 Sat 90

Transfusion Reaction Sample Collected at
Facility: Health Sciences Center Ward/Unit: GA5

Phlebotomist
Anne Nemia | RN | AN
Print Name | Classification | Initials

Collection Date: 4/18/2018 Time: 2230

New Onset Clinical Signs and Symptoms
☑ Chills/Rigors ☐ Hemorrhage ☑ Hypoxemia ☑ Shortness of Breath
☐ Urticaria ☐ Hemoglobinuria ☐ Jaundice ☑ Tachycardia
☐ Other Skin Rash ☐ Hypertension ☐ Oliguria ☐ Pain, Specify:
☐ Nausea/Vomiting ☑ Hypotension ☐ Shock ☐ Other

Measures Taken
☐ None Required
☑ Analgesics ☑ Chest X-Ray ☐ Steroids ☑ Transfusion Stopped
☐ Antibiotics ☑ Diuretics ☑ Supplementary O_2 ☐ Transfusion Restarted
☐ Antihistamines ☐ ICU Required ☐ Vasopressors ☐ Patient Blood Culture Ordered
☐ Antipyretics ☐ Mechanical Ventilation ☐ Other, Specify: ☐ Component Blood Culture Ordered

Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)

Donor ABO/Rh	Product Type	Donation Number	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers
O+	RBC		110	Apr.4 2145	Apr.4 2200	May 9/2018		

Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

Nursing Clerical Check
Nurse 1 Print name: Anne Nemia Date/Time: Apr 4/2018/2210
Nurse 2 Print name: Sue Thoms Discrepancies ☑ No ☐ Yes If Yes, Specify

Facility Blood Bank Clerical Check
☐ Component(s) Sent for Culture
Print Name Date/Time Discrepancies ☐ No ☐ Yes If Yes, Specify

Date / Time Received at Facility Blood Bank
Date / Time Received at Centre

BLOOD SERVICES COPY CM105 2016-11

This must be stamped with patients addressograph,

This is where the report will be sent when investigation is complete.

When filling this in the signature and initial must match the tube.

Only fill in symptoms that are new AFTER blood is hung.

What actions were done to treat patient.

Include sticker from blood product.