A Step Towards Healthy Community

SAMAST PATIDAR AAROGYA TRUST
KIRAN HOSPITAL
Multi Super Speciality Hospital & Research Center
Nr. Sumul Dairy, Surat, Gujarat - 395 004.
E-mail : info@kiranhospital.com | www.kiranhospital.com
Ph. : 0261-7161111 / 2534111 Fax : 0261-2534114

REPORT OF BLOOD TRANSFUSION REACTION

Patient Sticker

Blood Bank Licence No. : GB/183

Patient's Name : _____ Sex : _____

Date of Birth : ____/____/____ Age : _____ Years/months/days

Hospital : _____

Ward No. / Room No. _____ Bed No. _____

Hospital administration (patient registration) number : _____

Primary Diagnosis : _____

Transfusion Started on Date : _____ Time: _____ AM/PM

Transfusion Stopped / Completed on Date : _____ Time : _____ AM/PM

Pre-transfusion : Temp. Plus : /min, BP : / mm of Hg,

Respiratory rate : /min, SPO_2 %

Post-transfusion : Temp. Plus : / min, BP : / mm of Hg

Respiratory rate : / min, SPO_2 %

Whether patient was under anesthesia during transfusion : Yes / No

WB/Component (Type) : _____ Unit No. _____ Volume Transfused _____ ml

Indication for transfusion : _____

First time transfusion or repeat transfusion : _____

Blood Transfusion Reaction on Date : _____ Time : _____ AM/PM

Type of Blood Transfusion Reaction noted:

Generalized	Pain	Respiratory System	Renal	Circulatory
☐ Fever	☐ Chest Pain	☐ Dyspnea	☐ Hematuria	☐ Tachycardia
☐ Chills	☐ Abdominal Pain	☐ Wheeze	☐ Hemoglobinuria	☐ Hypertension
☐ Rigors	☐ Back /Flank pain	☐ Cough	☐ Oliguria	☐ Hypotension
☐ Itching / Pruritus	☐ Infusion site pain	☐ Hypoxemia	☐ Other	☐ Raised JVP
☐ Edema (Site)	☐ Other	☐ Bilateral Infiltration on Chest X-ray		☐ Arrhythmias
☐ Nausea				☐ Other
☐ Vomiting				
☐ Flushing		☐ Other		
☐ Urticaria				
☐ Anxiety				
☐ Restlessness				
☐ Jaundice				
☐ Other				

BLOOD CULTURE OF THE PATIENT : _____

Any other fluids administered simultaneously_____

_____

Please send the bag with remaining blood / component to the blood bank with fresh Blood samples of the patient (collected from different site) in 2 EDTA and 3 Plain tubes & first voided urine sample with this form completely filled.

Any other comments :

Outcome :

Date & Time of recovery : / / 20 at _____am/pm

Signature & Name of Dr. In-charge

FOR BLOOD BANK USE ONLY

Received form ☐ / bag ☐ / EDTA sample ☐ / Plain sample ☐ / Urine Sample ☐

On Date : Time : am/pm

Receiver's Signature