

YOUR HOSPITAL BLOOD BANK

FILE

RETURN TO BLOOD BANK AFTER TRANSFUSION

DO NOT BEGIN TRANSFUSION UNTIL ALL DISCREPANCIES ARE RESOLVED

1. CHECK NAME AND WRIST BAND NUMBER ON PATIENT'S WRIST IDENTIFICATION BAND AGAINST THE INFORMATION ON THIS FORM. *
2. CHECK CONTAINER INFORMATION AGAINST INFORMATION ON THIS FORM.
3. PERSONS IDENTIFYING THAT PATIENT IS RECEIVING CORRECT BLOOD PRODUCT SHOULD SIGN AND COMPLETE FIELDS BELOW.

YOUR HOSPITAL BLOOD BANK					FILE					
NAME OF RECIPIENT *					MEDICAL RECORD #					
WRIST BAND NO. *		LOCATION		RECIPIENT BLOOD TYPE						
CROSS MATCH STATUS										
UNIT NO.					COMPONENT		COMPONENT BLOOD TYPE			
EXPIRATION DATE		TIME	VOLUME	NO. IN POOL	SPECIMEN ID					
ACCOUNT NO.					TIME AT ISSUE: _____					
PERFORMED BY: _____					DATE		TIME			
					STARTED BY:					
					1. SIGNATURE					
					2. SIGNATURE					
					DATE STARTED		TIME STARTED			TRANSFUSION STOPPED/COMPLETED BY
					VOLUME TRANSFUSED		PATIENT REACTION		** IF "YES", NOTIFY BLOOD PHYSICIAN, AND COMPLETE "ADVERSE REACTION Form"	
							<input type="checkbox"/> NO <input type="checkbox"/> YES **			
PRE - TRANSFUSION:		TEMP	B P		POST - TRANSFUSION:		TEMP	B		
DO NOT REMOVE FROM UNIT UNTIL COMPLETION OF TRANSFUSION										
PART OF THE MEDICAL RECORD										