TRANSFUSION SERVICE — PRODUCT CHART COPY

------------------- PATIENT DATA ------------------- | ------------------------ BLOOD PRODUCT ------------------------

Patient ID: MR/Acct.#: | Unit #:

Name: Req#: | Component:

Location: ABO/Rh: | ABO/Rh:

Special Needs: | Remarks:

Sex: Birthdate: | Expiration Date:

Specimen In-Date/Time: Crossmatch Date/Time: Crossmatch Compatible?: Tech:
Antibody Screen:

****** REQUIRED TRANSFUSION CERTIFICATION AND DOCUMENTATION ******
(For Rh Immune Globulin injections with no adverse reaction, complete only the asterisked items)

Signed Blood Consent or Surgical Consent in Chart __________ Yes (required)

1. The transfusion or Rhogam MUST be started within 30 minutes of issue from the Blood Bank, and be completed within 4 hours.
2. If the temperature rises 2 degrees F or more from the baseline at any time during the transfusion, STOP the transfusion (leave the unit hanging), keep the line open with normal saline, notify the Blood Bank, and refer to PCS Policy PR-032.
3. Temperature route should remain constant.

We certify that we have checked the information on this form with Patient's wristband and started the transfusion.

*Transfusionist:______________________/______________________ Witness:______________________
Sign Print

*Transfusion Started:______/______/______ ________ [ ]AM/PM[ ] Blood Warmer Used? [ ]No Yes[ ] Temp______C
(date) (time)

*Rhogam Only - Entire syringe administered: [ ]Yes No[ ] If no, reason:______________________

Filter Used: [ ] Std Administration set (170-260 micron) [ ] Microaggregate (40 micron)
[ ] Pedi syringe filtered in Blood Bank (150 micron) [ ] Leukocyte Reduction Filter [ ] Other:______

VITALS:

Time:	Interval:	B/P	Pulse	Temp/Route: [ ]Oral [ ]Axillary [ ]Tympanic [ ]Other______
_____	Pre-Transfusion	_____	_____	_____
_____	15 Min from start	_____	_____	_____
_____	30 Min from start	_____	_____	_____
_____	1 Hour from start	_____	_____	_____
_____	2 Hours from start	_____	_____	_____
_____	3 Hours from start	_____	_____	_____
_____	Transfusion Completed	_____	_____	_____ (must be completed)

Transfusion Reaction Noted?
[ ]No
[ ]YES (complete below)
________ time stopped Tx
[ ] Notify Blood Bank
[ ] Notify Physician
[ ] Rxn Form Completed
Tx resumed after review:
[ ]No
[ ]YES ________ time
Authorized by:
____
Pathologist

Amount Transfused________ML

Transfusionist at end of Transfusion:______________________ Charge RN Review:__________

Any deviations from policy MUST be approved by a pathologist and documented