	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Document Code: HSAAS/PATO/BR156**
	REQUEST FORM FOR TRANSFUSION REACTION INVESTIGATION (BLOOD AND BLOOD COMPONENTS)

1. When a patient has an adverse reaction to any blood or blood component, **STOP** transfusion immediately. **URGENTLY** inform the doctor in charge of the patient and the Transfusion Medicine Unit (TMU).

2. Report all reactions and do the following:

   2.1 Preserve the blood bag and give a set with all attached labels. Seal it securely and send it immediately to the Transfusion Medicine Unit (TMU).

   2.2 Send the following samples for transfusion reaction investigation to the TMU and relevant laboratories.

   a. Post-transfusion sample 1 (immediate) (**PAT06111-TRANSFUSION REACTION**)
      i) Direct Coombs test (8-10ml EDTA)
      ii) Group crossmatch
      iii) Full blood picture (FBP)
      iv) Reticulocyte count
      v) Lactate Dehydrogenase (LDH)
      vi) Renal Profile (RP)
      vii) Liver Function Test (LFT)
      viii) Direct Bilirubin
      ix) Coagulation Profile (APTT/PT/INR)
      x) Urine examination for haemoglobin (Urine FEME)

   b. Post-transfusion sample II (after 24 hours) (for suspected acute haemolytic transfusion reaction only)
      - similar to (a)
      - to send the investigations after being informed by TMU Medical Officer if indicated.

   2.3 Please send for other appropriate investigations if necessary:
   a. Two sets of Blood Culture and Sensitivity (blood C&S) - from the patient and donor blood bag (for transfusion reaction with fever only)
   b. If suspected Disseminated Intravascular Coagulopathy (DIC), please send:
      i) D-dimer
      ii) Fibrinogen

Ward/Clinic: _____

Patient's Name: _____

IC/Passport No: _____ MRN: _____

Race: _____ Age: _____ Gender: _____

Diagnosis: _____

i. Date and time transfusion started:_____

ii. Date and time of onset of reaction: _____

iii. Date and time transfusion stopped/completed: _____

iv. Blood/ Blood Component Serial No: _____

v. Volume Blood/ Blood Component transfused: _____

vi. Blood Pressure: Before transfusion _____ After transfusion/During reaction _____

vii. Temperature: Before transfusion _____ After transfusion/During reaction _____

viii. Nature of Reaction: Tick off **(✓)** the positive symptoms/signs.

Fever		Shock		Haematuria	
Chills /Rigors		Jaundice		Dyspnoea	
Urticaria		Haemoglobinuria		Pain (Location of pain if present……..)	
Others (please specify):					

ix. Solution used for starting IV drip: N. Saline / 5% Dextrose / Others _____

x. History of previous transfusion: Yes / No

Date of last transfusion: _____

xi. History of previous transfusion reaction if any:

_____

_____

xii. Medication(s) relevant to reaction encountered (If any, please specify):

_____

_____

xiii. Applicable for female patients ONLY:

History of pregnancy:	Yes / No	No. of pregnancies:
History of abortion:	Yes / No	No. of abortions:

xiii. History of transplant: _____

Date of transplant: _____

Date: _____ Signature: _____

Name: _____

Official stamp:

PLEASE SEND THIS FORM TO TMU WITH ALL REQUIRED SAMPLES FOR INVESTIGATIONS