Clear Fields

Report of Suspected Hemolytic Transfusion Reaction

LifeSouth Community Blood Centers

For Internal Use Only
Case File Number:

Form Completed by (Name, Job Title):	Date Completed:
Phone #:	Facility:
Patient Name:	Patient ID #:

Date and time of onset of symptoms: / / at : ☐am ☐pm

Signs and Symptoms

- ☐ Fever
- ☐ Chills, rigors
- ☐ Flank, back pain
- ☐ Hypotension
- ☐ DIC
- ☐ Dark or red urine
- ☐ Oliguria
- ☐ Other; specify:

Vital Signs	Pre-Transfusion	Post-Transfusion		
	Date/Time:	Date/Time:	Date/Time:	Date/Time:
Temperature				
Heart Rate				
Blood Pressure				

Results of Investigation (to be completed by the facility's transfusion service)

(Fill out if different than above) Form Completed by (Name, Job Title):	
Date Completed:	Phone #:

Error detected during clerical check	☐ Yes	☐ No	
Hemolysis in plasma after transfusion	☐ Yes	☐ No	
Incompatibility detected on ABO/Rh confirmation	☐ Yes	☐ No	
Patient's DAT became positive after transfusion	☐ Yes	☐ No	
Incompatibility detected on repeat compatibility testing	☐ Yes	☐ No	
Patient's antibody screen changed after transfusion	☐ Yes	☐ No	
Culture results (if sent)	☐ Pos	☐ Neg	☐ NA

FAX TO (352) 224-1778 • CONFIRM FAX RECEIVED AT (888) 795-2707
AFTER NORMAL BUSINESS HOURS (9AM TO 5PM ET, M-F) FAX TO (352) 334-1029 • CONFIRM FAX RECEIVED AT (352) 334-1028