

(Attach Label Here or Complete Details)

Name: _____ NHI: _____

Gender: _____ DOB: _____ Age: _____ Ward: _____

☐ **Critical O negative** _____ **units**
(usually 1-2 units whilst blood group is determined)

RECORD OF ADMINISTRATION**Component / Product to be administered:****Patient Weight:** _____ **Kg**

Fresh Blood Components	Fractionated Blood Products (tick product and indicate dose where prompted)
<input type="checkbox"/> Red Blood Cells RBC	<input checked="" type="checkbox"/> RhD immunoglobulin (Anti-D; IM) 250iu / 625iu Gestation / 40 Circle dose
<input type="checkbox"/> Fresh Frozen Plasma FFP	<input type="checkbox"/> Hepatitis immunoglobulin (IM) (Hep Ig)
<input type="checkbox"/> Platelets PLAT	<input type="checkbox"/> Zoster immunoglobulin (IM) (Zoster Ig)
<input type="checkbox"/> Cryoprecipitate CRYO	<input type="checkbox"/> Tetanus immunoglobulin (IM) (Tet Ig)
Max 1-2 units will be issued unless discussed with Blood Bank	<input type="checkbox"/> Normal Immunoglobulin (IM) (Normal Ig)
<input type="radio"/> Granulocytes BUFFYCOAT	<input type="checkbox"/> Other
<input checked="" type="checkbox"/> Cardiac Emergency Cardiac Anaesthetists - phone BB	<input type="checkbox"/> Bone
<input type="checkbox"/> Obstetric Blood Box (Placenta percreta, increta, accreta)	<input type="checkbox"/> Skin
	<input type="checkbox"/> Tissue
	<input checked="" type="checkbox"/> Prothrombinex (IV) _____ iu/kg Dose _____ iu Life threatening bleed on warfarin YES / NO

For **massive bleeding** please "Initiate MHP" (Call "777"), receive stat pack/review patient then "Activate MHP" (Phone 80310)**Double Independent Checking at Bedside:** (two signatures required by IV endorsed Clinical staff)

♦ Any Pre-med or special requirements? eg. diuretic, irradiated, blood warmer

Patient ID - patient must be wearing a wristband or show photo ID

- ☐ Ask patient for full name & DOB
- ☐ Confirm Patient ID matches wristband details
- ☐ Patient is unable to communicate

Initials Initials

1st checker 2nd checker**Informed Consent** is valid and complete

- ☐ Check Patient ID matches prescription/consent

1st checker 2nd checker**Prescription** is present and complete1st checker 2nd checker**Blood Bag / Product label**

- ☐ Patient ID matches swing label
- ☐ Correct Component / Product
- ☐ Expiry date
- ☐ Unit / Batch numbers match swing label
- ☐ Inspect unit / product for colour and consistency

1st checker 2nd checker[RBC & Plasma compatibility chart](#) (Patient blood group is available on HCS)Attach swing label / batch label(s)
here post transfusion

(103mm x 54mm)

For blood components place swing label here
For blood products adhere one swing label and a batch sticker
from each bottle to this section

Date required	Requested by	Location	Product / Product Dose	Route	Rate	Start time	Finish time
				This is not the prescription			

Return unused components or products or those not required to Blood Bank within 30 minutes of issue

BB USE ONLY Init:

Date:

Time Issued: hrs

Print Name: 1st Checker: 2nd Checker:

2. Double Independent Checking at Bedside: *(two signatures required by IV endorsed Clinical staff)*

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BB USE ONLY Init:

Date:

Time Issued: hrs

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from each bottle to this sectionIf a patient develops signs or symptoms of a reaction during any blood transfusion/infusion, complete the **Acute Transfusion Reaction (ATR)** – **Notification to Blood Bank**. Algorithm on reverse of the reporting form has appropriate clinical management, reporting and suggested investigations.