MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are *requested.)*

- [ ] TYPE AND SCREEN
- CROSSMATCH

DATE REQUESTED: 26 April 03

DATE AND HOUR REQUIRED: 26 April 03 2000

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN:, ____

REQUESTING PHYSICIAN *(Print)*

(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW

I have collected a blood specimen on the below named patient, verified the name and ID No, of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

(b)(6)-2

DATE VERIFIED: Ed Apr 03

TIME VERIFIED: 1910

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.
(b)(6)-4	(b)(6)-4 P

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE

REMARKS: Exp 8 mayo3

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

(b)(6)-2 SON PERFORMING TEST (b)(6)-2 (b)(6)-2 1-28-08

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature)

(b)(6)-2

AT *(Hour)* 0043 (b)(6)-2 ON *(Date)* RR03

IDENTIFICATION

I have examined the Blood component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same Person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

(b)(6)-2

2nd VERIFIER *(Signature)*

(b)(6)-2 CCB/NC

PRE-TRANSFUSION

TEMP. 98.7 PULSE 115 BP 115/65

DATE OF TRANSFUSION: 4/27/03 0000

TIME STARTED: 0050

POST-TRANSFUSION DATA

AMOUNT GIVEN: 300 ML

TIME DATE COMPLETED: 0210 4/27/03

INTERRUPTED

REACTION

- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag. Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)* _____

SIGNATURE OF PERSON NOTING ABOVE

(b)(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER for typed or written entries give: NAME - *Last, first, middle; rank/rate; hospital number* and name of *facility.)*

(b)(6)-4

SEX: M

WARD: ICU #2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

(b)(3)-1

PERSONAL DATA PRIV AC 974

MEDIC ECORD COPY

MEDCOM - 5628

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check *one*)

RED BLOOD CELLS

- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _____ units)*
- ☐ CRYOPRECIPITATE *(Pool of _____ units)*
- ☐ *Rh* IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST (Check *ONLY* If *Red Blood Cell Products are requested.*)

- ☐ TYPE AND SCREEN
- ☒ CROSSMATCH

DATE: 26 April 03

DATE AND HOUR REQUIRED: 26 April 03 2000

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*

(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

(b)(6)-2

DATE VERIFIED: 26 Apr 03

TIME VERIFIED: 1910

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.	TEST INTERPRETATION		PREVIOUS RECORD CHECK:
		ANTIBODY SCREEN	CROSSMATCH	☐ RECORD ☒ NO RECORD
(b)(6)-4	(b)(6)-4	NEG	Comp	(b)(6)-2
DONOR	RECIPIENT			
ABO A	ABO A			
Rh POS	Rh POS			

☐ CROSSMATCH NOT REQUIRED FOR THE COMP (b)(6)-2 4-26-03

REMARKS: Exp: 8 May 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

(b)(6)-2

AT *(Hour)* 0208 ON *(Date)* 27APR03

IDENTIFICATION:

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

(b)(6)-2

2 (b)(6)-2

PRE-TRANSFUSION

TEMP. 99.0 PULSE 104 BP 118/79

DATE OF TRANSFUSION: 4/27/03

TIME STARTED: 0225

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

(b)(3)-1

POST-TRANSFUSION DATA

AMOUNT GIVEN: 460 ML

TIME DATE COMPLETED: 0425 4/27/03

INTERRUPTED

REACTION: ☒ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
- ☐ OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)* _____

SIG (b)(6)-2

SEX: M

WARD: CCU

BLOOD OR BLOOD COMPONENT TRANSFUSION

General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

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