Irish Blood Transfusion Service
Seirbhís Fuilaistriúcháin na hÉireann

Document Detail

Type: DIAG IBTS FORM
Document No.: IBTS/DIAG/FORM/0001[1]
Title: **REQUEST FOR TRANSFUSION REACTION INVESTIGATION**
Owner: QA DOC CON QA DOC CONTROL
Status CURRENT
Effective Date: 24-Aug-2021
Expiration Date: 24-Aug-2023

Review

Review: IBTS DOC REVIEW AND APPROVAL

Level	Owner Role	Actor	Sign-off By
1	DOCUMENT CONTROLLER	DEBBIE MAC RORY	DEBBIE MAC RORY
2	DIAGNOSTICS WRITER IBTS	AILEEN GRIFFIN	AILEEN GRIFFIN
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3	DIAGNOSTICS HEAD OF DEPT MRTC	KEVIN SHEEHAN	KEVIN SHEEHAN
4	QUALITY ASSURANCE REVIEWER IBTS	COLIN O'LEARY	COLIN O'LEARY

Change Orders

Changes as described on Change Order:	Change Order No.

Change Orders - Incorporated

Changes as described on Change Order:	Change Order No.
	IBTS/CO/0482/20

Valid on Day of Printing, Verify Current Version
Printed By: **Date:**

TITLE: REQUEST FOR TRANSFUSION REACTION INVESTIGATION

Change Description:

1. RCI to create new RCI SOP, MRTC to retain DIAG SOP 0063, removal of references to MRTC in new RCI SOP. 2. Update Smart train roles, referenced procedures and Training Requirements 3. Addition of Statutory Requirements in Section 1 4. Review and condense main body of Section 5 5. Reference to new IBTS/RCI/FORM where appropriate (applicable only where RCI acts as HBB) 6. Remove process flow from Section 5 and creation of new process flow in attachments. 7. Removal of Attachment 6.2 and re-format Attachment 6.2 (formerly Attachment 6.3). Identical and matching changes for IBTS/DIAG/SOP/0063:
   8. Re roles on IBTS/DIAG/FORM/0001
   The following roles need to be on it:
   MED SPMO MRTC
   MED CON MRTC
   DIAG THOD MRTC
   DIAG SMS MRTC
   DIAG MS MRTC

Reason for Change:

1. As part of CC342/19 separation of shared SOPs. 2. Periodic review of the SOP involved updates to Smart Train roles, referenced procedures and training requirements. 3. Statutory requirements were not listed in previous versions. 4. Section 5 required some re-wording and clarification to improve the readability of the procedure. 5. To replace the use of BT – 0311. 6. Process flows should be captured as an attachment. 7. Attachment 6.2 was removed due to repetition. 8. Role identification for IBTS/DIAG/FORM/0001

Change order No.:

IBTS/CO/0482/20

Referenced Procedures

IBTS/DIAG/SOP/0063

SmartSolve Roles

DIAG THOD MRTC	MED CON MRTC
DIAG SMS MRTC	MED SMO MRTC
DIAG MS MRTC	

Training Type

Staff Trained in Previous Version	New Staff
Read Only	Procedural Training (Read Through with Trainer)

SmartSolve Document Category

Category	Mobile	Cryobiology	Website	GDP
Yes/No	No	No	Yes	No

TITLE: REQUEST FOR TRANSFUSION REACTION INVESTIGATION

Diagnostics Laboratory, IBTS, MRTC Tel: 021 480 7400 Fax: 021 432 3315

Please contact the Diagnostics Laboratory, IBTS as soon as possible to inform them of a transfusion reaction:

Please complete this form and provide the following:

1. 7ml Post Transfusion EDTA sample (Children 2mls)
2. 7 ml Clotted sample (Children 2mls)
3. Completed BT7 form
4. Used Sealed Blood packs and giving set

Patient and Hospital Information			
Patient Surname		**Patient Forename**	
Patient Address			
Date of Birth		**Hospital Number**	
Hospital		**Gender**	
Consultant		**Contact number**	

Underlying diagnosis:
Reason for transfusion:

Product Information

Please tick Implicated Product: Red Cells ☐ Platelets ☐ Plasma ☐ Other ☐

Please specify Unit number implicated:

Unit numbers already transfused: 1. 2. 3.

Transfusion Event Information

Date & Time of Implicated Transfusion: ____/____/____ at _____ Hours
Interval between commencement of transfusion and reaction: _____ Hours
Approximate Volume of blood transfused: _____ ml

Description of Transfusion reaction Symptoms *please tick boxes and fill required information fields*

Baseline Temperature before the commencement of transfusion: _____ °C
Temperature change from baseline: > 1.5°C ☐ <1.5°C ☐ No Change ☐
Baseline BP before commencement of transfusion:_____
Change in BP: BP ↑: mm Hg_____ BP ↓: mm Hg_____
SpO2 Level Post Transfusion_____
Tachycardia Yes ☐ No ☐ _____

Please Tick if present

Rigors		**Facial Oedema**		**Back Pain**		**Jaundice**	
Shortness of Breath		**Vomiting**		**Cough**		**Pain @ IV site**	
Rash		**Chest Pain**		**Urticaria**		**Haemoglobinuria Cyanosis**	

History of Pyrexia in previous 24 hours: Yes ☐ No ☐
History of previous transfusion reaction*: Yes ☐ No ☐
***If Yes, please state date if known: _____**
Other relevant information: _____

Report completed by: _____ Date: _____

Doctor's Name: _____ MCRN: _____ Bleep No: _____