Cayuga HEALTH

Downtime Transfusion Documentation Form

Cayuga Medical Center ☐ Schuyler Hospital ☐

Patient Name: _____

Patient DOB: _____ Patient Blood Type: _____

Patient Antibody Screen: _____ Antibody ID: _____

Special Transfusion requirements: _____

Unit Compatibility (circle): Compatible Least Incompatible Uncrossmatched

Unit # _____ Exp:_____ Component type (circle): RBC PF24 Platelets Cryo

Unit ABO (circle): A B O AB **Rh type** (circle): Negative Positive **Antigen Negative**: _____

Issuing: Date: _____ Time: _____ Location: _____ *Signature indicates visual inspections were passed*

Tech: _____ Courier: _____

Returning: Date: _____ Time: _____ Location: _____ *Signature indicates visual inspections were passed*

Tech: _____ Courier: _____

Nurse/MD initials		Transfusion checklist
		Physician order is verified and consent has been obtained
		The patient's name and DOB match the blood component label, and wristband
		The patient's ABO group and Rh type
		The unit #, donor ABO group, and Rh type if required
		The unit is not expired
		The interpretation of crossmatch is acceptable, and any special requirements are met

Signature of the RN/MD transfusionist: _____ Initials: _____Date:_____ Time: _____

Signature of 2nd Nurse: _____ Initials: _____Date:_____ Time: _____

UNITS MUST BE TRANSFUSED WITHIN 4 HOURS OF TIME OF ISSUE:

Issue Time: _____ Start Time: _____ Completion Time: _____

☐ Patient transferred from _____ to OR see TAR for additional documentation

TRANSFUSION VITALS

First 15 min: 1-2mL/min (60 mL/hour). After 15 min: 4 mL/min (240 mL/hour) Alt rate: _____mL/hour

Initial fluid warmer temp: _____° C Warmer ID: Ranger and/or Level 1 infuser

Temp Source: _____ (the temperature source should be consistent throughout the transfusion)

	Date (M/D/Y)	Time	BP	Temp	Pulse	Resp	RN Mnemonic
Pre (within 30 min)	/ /		/	.			
15 min	/ /		/	.			
Post	/ /		/	.			
Post 1 HR	/ /		/	.			
Post 4 HR	/ /		/	.			

Check box if vitals are documented on the Anesthesia Record ☐

Transfusion-related adverse reaction: ☐ Yes ☐ No *Inform Blood Bank Immediately if Yes*

Volume transfused: _____ mL

See sticker on unit for signs/symptoms