(FOM20/MIP/PMS/SOP/001

MINISTRY OF HEALTH
PHARMACY AND POISONS BOARD
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IN CONFIDENCE

ADVERSE TRANSFUSION REACTION FORM

In the event of a severe reaction following transfusion of blood or blood products please complete this form and send it to the laboratory with the specimens listed below.

PATIENT INFORMATION

Patient name:_____ Age: _____
Gender: ☐ Male ☐ Female Patient No.: _____

Diagnosis: _____
Ward:_____
Pre-transfusion HB: _____
Reason for transfusion: _____
Current Medications: _____

Obstetric History: ☐ N/A ☐ Gravid_____☐ Para ____
Previous Transfusion: ☐ Yes ☐ No
Comment: _____
Previous Reactions: ☐ Yes ☐ No
Comment: _____

REACTION INFORMATION

Type of reaction

1. General: ☐ Fever ☐ Chills/Rigors ☐ Flushing
   ☐ Nausea/ Vomiting
2. Dermatological: ☐ Urticaria, ☐ Other skin rash
3. Cardiac/Respiratory: ☐ Chest pain ☐ Dyspnoea
   ☐ Hypotension ☐ Tachycardia
4. Renal: ☐ Haemoglobinuria- Dark urine ☐ Oliguria
   ☐ Anuria
5. Haematological: ☐ Unexplained bleeding
6. Others (Specify): _____

Vital Signs: At Start: BP_____ During (15min) BP _____ At stop: BP_____
T_____ T _____ T_____
P_____ P _____ P_____
R_____ R _____ R _____

COMPONENT INFORMATION

Name of Nurse/Doctor: _____

Signature: _____

Type of component	Pint No	Expiry Date	Volume Transfused

Specimens required by the laboratory

1. *10mls post-transfusion whole blood from patient from plain bottle*
2. *2mls of blood in EDTA bottle*
3. *10mls First Void Urine*
4. *The blood that reacted together with the attached transfusion set*
5. *All empty blood bags of already transfused unit*

LAB INVESTIGATION: (Transfusion manager)

1. Recipient's blood supernatant:
Hemolysis ☐Present ☐ Absent ☐ Equivocal
If present ☐ Mild ☐ Moderate ☐ Marked
2. Recipient's blood:
Agglutination ☐ Present ☐ Absent
3. Haematological results: WBC_____HB_____RBC_____HCT_____MCV _____
MCH_____MCHC_____PLT _____

Film Rbc:_____Wbc:_____PLt: _____

4. **Donor blood supernatant**:
Hemolysis ☐ Present ☐ Absent

5. **Age of donor pack**: _____

6. **Culture donor pack:** Results: _____

7. **Culture recipient blood:** Results: _____

8. Compatibility testing recipient serum (pretransfusion sample) and donor cells (pack)

Compatible	Saline Rt	☐	Saline 37	☐	AHG	☐	Albumin 37 ☐
Incompatible	Saline Rt	☐	Saline 37	☐	AHG	☐	Albumin 37 ☐

9. If negative (inconclusive results in 8) set up compatibility with enzyme treated cells Result: _____

10. In case of blood group O transfused to A or B or AB individual: Establish from the donor unit
Anti A titres_____Anti B titers _____

11. Urinalysis _____
12. Evaluation: Diagnosis
13. Was the adverse reaction related to transfusion?
☐ Yes ☐ No ☐ Inconclusive

Reporter Details

Name of Initial reporter:	**Cadre/designation:**	**Mobile no:** **Email:**	**Date of report:**
Name of Person Submitting to PPB if different from reporter:	**Cadre/designation:**	**Mobile no:** **Email:**	**Date of Submission:**

You need not be certain..... just be suspicious!

Your support towards the National Pharmacovigilance system is appreciated
Submission of a report does not constitute an admission that medical personnel or manufacturer or the product caused or contributed to the event.
Patient's identity is held in strict confidence and program staff is not is not expected to and will not disclose reporter's identity in response to any public request.
Information supplied by you will contribute to the improvement of drug safety and therapy in Kenya. Once completed please send to:
The Pharmacy and Poisons Board on the above address

FOR OFFICIAL (PPB USE ONLY)

ADR Report No: ...../...../..... Date Received.....

Vigiflow Entry Number ..... Date Committed: .....