NEW YORK STATE DEPARTMENT OF HEALTH
Blood Resources Program
Biggs Laboratory, Wadsworth Center, Empire State Plaza, Albany, New York 12237
E-mail: clep@health.ny.gov
Web: www.wadsworth.org/regulatory/blood-program

Blood Transfusion Record

Patient Name (Print)	DOB
Patient ID	Date

Transferring Hospital Name	Transferring Hospital Blood Bank Phone Number
Receiving Hospital Name	Receiving Hospital Blood Bank Phone Number

Pre-transport Patient/Blood Component Identification

- ☐ Blood components are packed in a validated transport container with a label indicating the name of the receiving hospital blood bank
- ☐ Patient wristband ID compared with ALL blood component units at patient's bedside with hospital staff
- ☐ Number and type of components agrees with physician's orders
- ☐ Patient has a dedicated venous access line with only blood and/or 0.9% NaCl running
- ☐ Manifest/Packing slip and pre-transfusion blood specimen (if available) included

Hospital Staff (Print Name)	Hospital Staff Signature
EMT-CC or Paramedic (Print Name)	EMT-CC or Paramedic Signature

Ambulance Service (Print Name)	Agency Code Number

Patient/Blood Component Identification of Units Initiated During Transport (If Applicable)

- ☐ Number and type of components agrees with physician's orders
- ☐ Patient has a dedicated venous access line with only blood and/or 0.9% NaCl running
- ☐ Patient wristband ID compared with ALL blood component units at patient's bedside

EMT-CC or Paramedic (Print Name)	EMT-CC or Paramedic Signature

Vital signs, including patient temperature, are to be monitored every 10 minutes and recorded on Pre-Hospital Care Report (PCR).

Component	Unit ID Number	Unit ABO/Rh	Start		End		Adverse Reaction	
			Date	Time	Date	Time	Yes* (Record details on PCR)	No
							☐	☐
							☐	☐
							☐	☐

**If acute transfusion reaction is suspected: STOP THE TRANSFUSION, replace all tubing and maintain IV line with 0.9% NaCl. Immediately contact physician for evaluation and treatment orders. Do not initiate another unit unless advised to do so by a physician. EMT-CC or Paramedic must contact their Medical Control through their regionally approved system. Nurse from the transferring hospital who is responsible for the patient during interfacility transport must contact the transferring hospital's physician.*

Medical Control Contacted (Print Name of Medical Control Physician)	EMT-CC or Paramedic Signature
Transferring Facility Contacted (Print Name of Transferring Hospital's Physician)	Nurse from Transferring Facility Signature

- ☐ **Transfusion Reaction NOT Suspected (Check each item as completed.)**
- ☐ Empty blood bags discarded as medical waste
- ☐ Transport container given to receiving hospital
- ☐ Unused blood components given to receiving hospital
- ☐ Completed Blood Transfusion Record form given to receiving hospital
- ☐ Completed PCR given to receiving hospital
- ☐ Manifest/Packing slip and pre-transfusion specimen given to receiving hospital

- ☐ **Transfusion Reaction Suspected (Check each item as completed.)**
- ☐ All blood bags & used administration sets given to receiving hospital
- ☐ Transport container given to receiving hospital
- ☐ Unused blood components given to receiving hospital
- ☐ Completed Blood Transfusion Record form given to receiving hospital
- ☐ Completed PCR given to receiving hospital
- ☐ Manifest/Packing slip and pre-transfusion specimen given to receiving hospital

Receiving Hospital Staff (Print Name)	Receiving Hospital Staff Signature	
Title	Date	Time

Copies of Completed Blood Transfusion Record Form to Receiving Hospital Blood Bank, Ambulance Transfusion Service, Issuing Hospital Emergency Room and Blood Bank