

## Heading Home After A Transfusion

You received a blood transfusion today. Although rare, sometimes people react to a transfusion. This may happen within hours, or after a few days. These reactions are usually mild, but it is still important to report these reactions.

### SYMPTOMS TO WATCH FOR:

First 24 hours after your transfusion:	24 hours to 14 days after your transfusion:
<ul style="list-style-type: none"> <li>• rash, hives, itching</li> <li>• feeling sick, vomiting</li> <li>• difficulty in breathing</li> <li>• increased coughing</li> <li>• headache</li> <li>• disturbed by bright light</li> <li>• feeling very hot or feverish</li> <li>• chills</li> <li>• back pain</li> <li>• red/brown urine</li> </ul>	<ul style="list-style-type: none"> <li>• headache</li> <li>• feeling sick, vomiting</li> <li>• disturbed by bright light</li> <li>• feeling very hot or feverish</li> <li>• chills</li> <li>• back pain</li> <li>• red/brown urine</li> <li>• yellow skin colour or yellow eyes</li> <li>• feeling unusually or extremely tired</li> </ul>

### IF SYMPTOMS ARE SERIOUS

Contact your doctor or go to the nearest emergency department immediately.  
Tell the staff that you recently received a blood transfusion.

### TO CONTACT YOUR DOCTOR

Please call Children's & Women's Health Care Center at **604-875-2161** and ask to speak to the doctor on call for your health care team.

If you have any of these symptoms **please fill out the form on the other side of this page** and send it to Children's & Women's Health Centre.

#### Return your completed form:

- By email: [TransfusionSafetyNurseClinician@cw.bc.ca](mailto:TransfusionSafetyNurseClinician@cw.bc.ca)
- By Fax to: **Transfusion Medicine Lab (TML)** at **604-875-2815**
- Mail: C&W Health Centre, TML Room T2-711, 880 West 28<sup>th</sup> Ave, Vancouver, BC V5Z 4H4
- In person to: **Out Patient Clinic**

# Out Patient Transfusion Reaction Report Form

Place addressograph here

Date of Transfusion: \_\_\_\_\_

Product Transfused: \_\_\_\_\_

Patient location for transfusion: \_\_\_\_\_

**Please complete the following:**

Put a tick mark in the box that describes how you felt. **If you have no symptoms, DO NOT send this form.**

In the <b>first 24 hours</b> after transfusion felt/had:	<b>24 hours to 14 days</b> after your transfusion felt/had:
<input type="checkbox"/> a rash <input type="checkbox"/> hives <input type="checkbox"/> itching <input type="checkbox"/> unwell <input type="checkbox"/> vomited <input type="checkbox"/> difficulty in breathing <input type="checkbox"/> increased coughing <input type="checkbox"/> headache <input type="checkbox"/> sensitive to bright light <input type="checkbox"/> very hot or feverish <input type="checkbox"/> chills <input type="checkbox"/> back pain <input type="checkbox"/> red/ brown urine	<input type="checkbox"/> a headache that would not go away <input type="checkbox"/> vomited <input type="checkbox"/> sensitive to bright light <input type="checkbox"/> very hot or feverish <input type="checkbox"/> chills <input type="checkbox"/> back pain <input type="checkbox"/> red/brown urine <input type="checkbox"/> yellow skin or yellow eyes <input type="checkbox"/> unusually or extremely tired

Did you take any medication for your symptoms?  No  Yes If yes, list the medications: \_\_\_\_\_

Did you take your temperature?  No  Yes If yes what was the reading? \_\_\_\_\_ degrees

Date and time you took your temperature: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Did you contact your doctor?  No  Yes Doctor's Name: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Best phone numbers to reach you at: \_\_\_\_\_

**Thank you for completing this form.**

As per section 26(c) of FOIPPA the information is being collected for the purposes of 1) the protection of public health through a monitoring system for reporting of adverse reaction to blood which 2) provides data that will be used for managing risks related to blood transfusion in Canada [Transfusion Safety Nurse Clinician, Transfusion Safety Office, Room 1P58, 4500 Oak Street, Vancouver, BC, V5Z 1W5].