BLOOD COMPONENT PRESCRIPTION & ADMINISTRATION CHART

Note: Some patients will require CMV negative and/or irradiated blood components. PLEASE SEE OVERLEAF.

Before administering a blood component it is vital for the safety of your patient to ensure that the special requirements section overleaf is fully completed.
DO NOT PROCEED WITHOUT FIRST CHECKING THIS INFORMATION.

PRE-TRANSFUSION CHECKLIST:	A	B	C	D	E	F	G	H	I	J
Written consent has been obtained (as appropriate)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Special Requirements section completed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pre-transfusion observations recorded	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Positive Patient Identification confirmed against the Patient ID band and the blood component tag.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Hospital No.:

Surname: AFFIX PATIENT

Forenames: LABEL HERE

D.O.B.: Gender: M / F

Address:

In the event that BloodTrack Tx is not operational, a second signature and time must be recorded here.

	PRESCRIPTION							ADMINISTRATION					
	Date of Transfusion	Blood Component Type (e.g. red cells, platelets etc)	Dose / Volume	Special Requirements	Rate of Infusion	Diuretic required (Prescribe on Patient's drug chart)	Doctor (Sign & Print Name)	Date blood component actually transfused	Donation number of unit (i.e. G092....) (Affix sticker)	Administered by: (Sign & Print Name)	Checked by: (Sign & Print Name)	Time started	Time finished
A													
B													
C													
D													
E													
F													
G													
H													
I													
J													

All blood components must be administered via a 'blood giving set' and all transfusions must be completed <u>within 4 hours</u> of leaving controlled storage.

SPECIAL REQUIREMENTS

This section MUST be completed prior to the prescribing of all blood components.

Indication Checklist – tick box if indication applies ✓		Yes (Tick)
Indications for **CMV NEGATIVE** Blood Components	Neonates (i.e. up to 28 days post ***ESTIMATED*** delivery date)	
	CMV antibody negative patients with haematological or other disease who are likely to receive allogeneic bone marrow transplant (BMT) and/or peripheral blood stem cell transplant (PBSCT)	
	CMV negative recipients of allogeneic bone marrow transplant and/or peripheral blood stem cell transplant	
	Elective transfusions during the course of pregnancy (not labour and/or post delivery)	
	All intra-uterine transfusions	
Indications for **IRRADIATED** Blood Components	BMT/PBSCT allograft recipient	
	BMT/PBSCT autograft recipient - no Total Body Irradiation (TBI) <3 months post transplant	
	Autograft recipient with TBI conditioning <6 months post transplant	
	Due for BMT or PBSCT in the next seven days	
	Hodgkin's Disease (all patients regardless of stage)	
	Suspected or confirmed congenital cellular immune deficiency state (eg. DiGeorge Syndrome)	
	Neonate (<6 months old) due to receive a red cell exchange transfusion	
	Patients receiving Fuldarabine, Cladribine (2CDA), Pentostatin (2 deocycoformcycin), Bendamustine, CAMPATH, Clofarabine, ATG (not essential following ATG in recipients of solid organ transplant)	
	Due to receive or has previously received intra-uterine transfusion	
	Due to receive Granulocytes, HLA-matched platelets or donations from 1st or 2nd degree relatives	

If no Special Requirements apply, please tick this box ☐

Signature: Date:

Comments

Reviewed

Signature: Date:

Please see the hospital transfusion policy for further background detail.

Adapted from Northampton General Hospital SR Form