MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable): 1U ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 5MAY03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify): NA

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: NA
HEMOLYTIC DISEASE OF NEWBORN? ___

REQUESTING PHYSICIAN (Print)
DR. [b)(6)-2]

DIAGNOSIS OR OPERATIVE PROCEDURE: DX: GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED: ON RECORD

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 6MA403 1640418

TRANSFUSION NO. [b)(6)-4]

DONOR
ABO O
Rh NEG

RECIPIENT
ABO AB
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMP IS AHG

PREVIOUS RECORD CHECK:
- [X] RECORD
- [X] NO RECORD

[b)(6)-2]

SIGNATURE OF PERSON PERFORMING TEST [b)(6)-2]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

5MAY03

REMARKS:

6448K7676

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature)

AT [b)(6)-2] ON (Date) 5MAY03

I [illegible] the Blood Component container label and this form and I find [illegible] information identifying the container with the intended recipient match item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st [b)(6)-2]

2nd VERIFIER (Signature) [b)(6)-2] MAG, AN

PRE-TRANSFUSION TEMP. 100.4 PULSE 101 BP 147/71

DATE OF TRANSFUSION: 05MAY 2003

TIME STARTED: 1600

PATIENT IDENTIFICATION · USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

[b)(6)-4]

1CU2

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE COMPLETED	INTERRUPTED
all ML	1800	5/5/03	

REACTION
- [ ] NONE
- [ ] SUSPECTED BP 130/76 HR 87 Temp 98.6

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify) _____

[illegible] OF PERSON NOTING ABOVE [b)(6)-2]

SEX: M

WARD: 1CU2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 5767

MEDICAL *RECORD* COPY

EDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS: CLOT IN LAB

TYPE OF REQUEST (Check *ONLY* if Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 09 MAY 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT/DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN: ____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: Previous sample

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 0398 EXP 14MAY03

TRANSFUSION NO.: 423

PATIENT NO.:

DONOR: ABO A; Rh POS

RECIPIENT: ABO AB; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN:

CROSSMATCH: COMP (37 RT AHG)

PREVIOUS RECORD CHECK: [V] RECORD 05 [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

2H6X7597

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 1950 ON *(Date)* 9MAY03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2 9/C3H

2nd VERIFIER *(Signature)* (b)(6)-2

PRE-TRANSFUSION

TEMP. 97.2° Tx PULSE 113 BP 67/27

DATE OF TRANSFUSION: 9MAY03

TIME STARTED: 1958

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME COMPLETED: 2010

DATE INTERRUPTED: 9MAY03

REACTION: [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)* _____

SIGN (b)(6)-2

SEX: M

WARD: ICU 2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 5768

DICAL **RECORD**

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

MPONENT REQUESTED **(Check one)**

- [ ] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE *(pool o r ~ n i b)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

LUME REQUESTED *(If applicable)*

_____ ML

MARKS: CLOT IN LAB

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE. IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN? ___

REQUESTING PHYSICIAN *(Print)*

(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

Previous Sample

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

NIT NO. 1260414 4p 14MAY03

TRANSFUSION NO. 423

PATIENT NO.

>NOR

BO A

h POS

RECIPIENT

ABO AB

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: COMP IS AHG

PREVIOUS RECORD CHECK:

[x] RECORD 05 [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

(b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

644I5709

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

T (Hour) 1950 ON (Date) 9 MAY 03

DENTIFICATION

have examined the Blood Component container label and this form and I ind all information identifying the container with the intended recipient natches item by item. The recipient is the same Person named on this Blood Component Transfusion Form and on the patient identification tag.

st VERIFIED

(b)(6)-2

nd VERIFIER

(b)(6)-2

SS6 9 MAY 03

PRE-TRANSFUSION

TEMP. PULSE BP

DATE OF TRANSFUSION: 9 MAY 03

TIME STARTED: 1955 2010

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME DATE COMPLETED: 2025 9 MAY 03

INTERRUPTED

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)*

(b)(6)-2

SIGNATURE OF PERSON NOTING ABOVE

SEX: M

WARD: ICU2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45,505
518-122

MEDICAL RECORD COPY

MEDCOM - **5769**

EDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

MPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

OLUME REQUESTED *(If applicable)*
____ ML

EMARKS: CLOT IN LAB

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 09 MAY 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR **OPERATIVE PROCEDURE**

I have collected a blood **specimen on the** below named patient, **verified the name and** ID No. of the patient and **verified the specimen tube** label to be correct.

SIGNATURE OF VERIFIER: Previous Sample

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

NIT NO. 1260438 XP 14May03

TRANSFUSION NO. 423
PATIENT NO.

ONOR
ABO A
th POS

RECIPIENT
ABO AB
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP IS AHG

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: Exp 14May03

6466330

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

NSPECTED AND ISSUED BY *(Signature)*
(b)(6)-2

AT *(Hour)* 1821 ON *(Date)* 9 May 03

DENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)-2

(b)(6)-2

PRE-TRANSFUSION
TEMP. 98.1 PULSE 80 BP 114/49

DATE OF TRANSFUSION: 09 MAY 03

TIME STARTED: 1730

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME COMPLETED: 1810

DATE INTERRUPTED: 09 MAY 03

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGN (b)(6)-2

SEX M

WARD ICU 2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

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DICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

MPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

)LUME REQUESTED *(If applicable)*

_____ ML

EMARKS: CLOT IN LAB

TYPE OF REQUEST (Check ONLY *if* Red Blood Cell Products are requested.)

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 9 MAY 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: UNK

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN? ___

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: Previous Sample

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UIT NO: 2770481 @ 14May03

TRANSFUSION NO. 423

PATIENT NO.

ONOR

BO A

h POS

RECIPIENT

ABO AB

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP IS

PREVIOUS RECORD CHECK:

[X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

(b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

6461438H

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

XSPECTED AND ISSUED BY (Signature)

IT (Hour) 1532 (Date) 9May03

DENTIFICATION

have examined the Blood Component container label and this form and I ind all information identifying the container with the intended recipient natches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)-2 CPT

(b)(6)-2 IC

PRE-TRANSFUSION

TEMP. 99.3 PULSE 99 BP 114/47

DATE OF TRANSFUSION: 9MAY03

TIME STARTED: 1553

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN _____ ML

TIME DATE COMPLETED: 1834 05May03

INTERRUPTED: 1834

REACTION [X] NONE [ ] SUSPECTED

120/53-55 97.6 102Rs

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

(b)(6)-2 [illegible] NOTING ABOVE

SEX: M

WARD: 1C42

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD *COPY*

MEDCOM - **5771**

EDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

RED BLOOD CELLS

- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable)

unit ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 09 May 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify): N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN (Print): (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: Previous Sample

DATE VERIFIED: 9 May 03

TIME VERIFIED: 2116

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 4660769 XP 9 May 03

TRANSFUSION NO. 423

PATIENT NO.

DONOR

BLOOD GROUP: O

Rh: POS

RECIPIENT

ABO: AB

Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp (S)

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 9 May 03

REMARKS:

Seq# 134C7303394

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

UNSPECTED AND ISSUED BY (Signature): (b)(6)-2

AT (Hour) 2116 ON (Date) 9 May 03

IDENTIFICATION:

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERI (b)(6)-2 MD.

2nd (b)(6)-2 MJ CRNA

PRE-TRANSFUSION

TEMP. 36 PULSE 104 BP 97/47

DATE OF TRANSFUSION: 9 May 03

TIME STARTED: 2120

PATIENT IDENTIFICATION -USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME DATE COMPLETED: 2135 9 May

INTERRUPTED: all

REACTION

- [x] NONE
- [ ] SUSPECTED

108/59/92 / 100% Sat.

If reaction is suspected – IMMEDIATELY

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [x] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2

SEX: M

WARD: ICU2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 5772

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

TYPE OF REQUEST (Check *ONLY* if Red Blood Cell *Products* are requested.)

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 09 May 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

I have collected a blood specimen on the below named patient, verified the name and ID NO. of the patient and verified the specimen tube label to be correct

SIGNATURE OF VERIFIER: Previous Sample

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.
4651295	423
9 May 03	PATIENT NO.

DONOR	RECIPIENT
ABO O	ABO AB
Rh pos	Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE

REMARKS:

TSACT3U6673

SECTION III – RECORD OF TRANSFUSION

PRE-TAANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT (Hour) ____ ON (Date)

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER: (b)(6)-2

2nd VERIFIER *(Signature)*: (b)(6)-2

PRE

TEMP. 37 PULSE 107 BP 94/42

DATE OF TRANSFUSION: 9 May 03

TIME STARTED: 2137

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
1 unit ML	2155 9 May 03	

REACTION: [X] NONE [ ] SUSPECTED

107/64 95 13

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag. Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [X] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2

SEX: M

WARD: ICU 2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 5773

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Chech one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Producla are requested.)*

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 9 May 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2 Dr.

DIAGNOSIS OR OPERATIVE PROCEDURE: CSW

I hove collected a blood specimen on the below named patient, verified the name and ID NO. of the patient and verified the specimen rube label to be correct.

SIGNATURE OF VERIFIER: Previous sample

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 4653081

Exp 9 May 03

DONOR

ABO: O

Rh: Pos

TRANSFUSION NO.

PATIENT NO.: #423

RECIPIENT

ABO: A

Rh: Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp IS AHG

PREVIOUS REC. D CHECK:

- [X] RECORD
- [ ] NO RECORD

SIG(b)(6)-2TURE OF PERSON PERFORMING TEST

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 9 May 03

REMARKS:

BAC7113624

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* ON *(Date)* 9 May 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (S (b)(6)-2

2nd VERIFIE

(b)(6)-2

PRE-TR SION

TEMP. 98 PULSE 115 BP 75/35

DATE OF TRANSFUSION: 9 May 03

TIME STARTED: 2310

PATIENT IDENTIFICATION . USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle: rank/rate; hospital number and name of facility.)*

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE COMPLETED	INTERRUPTED
1 unit ML	2326	9 May	Yes

REACTION

- [ ] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY: 103/50, 100, 12

1. Discontinue transfusion. treat shock if present. keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)* _____

NOTING ABOVE

SIGNATURE OF PERSON (b)(6)-2

SEX: M

WARD: OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 5774

★U.S.GPO:1993-0-337-272/80075

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool o £ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable)
Unit ML

REMARKS:

TYPE OF REQUEST (Check ***ONLY*** *if Red* Blood Cell Products are *requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 9 May 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
N/A
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*
Dr. [redacted]

DIAGNOSIS / OPERATIVE PROCEDURE
GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER
Previous Sample

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 4657284 Exp 11 May 03
DONOR
ABO O
Rh Pos

TRANSFUSION NO.
PATIENT NO. 423
RECIPIENT
ABO AB
Rh Pos

BAC 33547

TEST INTERPRETATION
ANTIBODY SCREEN: N/A
CROSSMATCH: Comp (IS) (37 AHG)

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

dw

SIGNATURE OF PERSON PERFORMING TEST
[redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature)
[redacted]

AT (Hour) 0904 ON (Date) 11 May 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification rag.

1st VERIFIER *(Signature)*
[redacted] LT, AN

[redacted]

RANSFUSION

TEMP. 98.7 1142 BP 133/77

DATE OF TRANSFUSION 11 MAY 03 TIME STARTED 0930

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

POST-TRANSFUSION DATA

AMOUNT GIVEN 350-400 ML

TIME DATE COMPLETED INTERRUPTED
1015 11 MAY 03

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present. keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set. and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, *cloth, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE
[redacted] LT, AN

SEX M WARD TCU2

#423

MEDCOM - 5775

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

★U.S.GPO:1993-0-337-272/80075

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN

OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 1 unit ML

REMARKS: CLOT IN LAB

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 10 MAY 0500

DATE AND HOUR REQUIRED: 10 MAY 0500

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify): N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN (Print) (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

I have collected a blood specimen on the below named patient, verified the name and ID No of the patient and verified the specimen tube label to be correct

SIGNATURE OF VERIFIER: Previous sample

DATE VERIFIED

TIME VERIFIED

SECTION II – CAE-TRANSFUSION TESTING

UNIT NO. 4640110 EXP 11 May 03

TRANSFUSION NO.

PATIENT NO. 423

DONOR

RECIPIENT

ABO: O

ABO: AB

Rh: POS

Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatible (5) (5)

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS:

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

(b)(6)-2

SIGNATURE OF PERSON PERFORMING TE (b)(6)-2

Segment BAC 372482

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) (b)(6)-2

AT (Hour) 1007

ON (Date) 11 May 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)-2

(b)(6)-2

PRE-TRANSFUSION

TEMP. 98.6 PULSE 117 BP 128/64

DATE OF TRANSFUSION: 11 May 03

TIME STARTED: 1030

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350-400 ML

TIME DATE COMPLETED, INTERRUPTED: 1330 11 MAY 03

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify) ____

SIGNATURE OF PERSON (b)(6)-2 OTING ABOVE

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries)
NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)-4

X M

WARD ICU 2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 5776

518-124

NSN 7540-00-634-4135

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one.):

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable): 1 ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 14-May-03

DATE AND HOUR REQUIRED: 1430

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN (Print): (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: (2) Dehydration

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

(b)(6)-2

TIME VERIFIED: 1 May 03 0900

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 2770474 14 May 03

TRANSFUSION NO. 423

PATIENT NO.

DONOR: ABO A; Rh Pos

RECIPIENT: ABO AB; Rh Pos

6465

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp IS 37° AHG

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

(b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 14 May 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT (Hour): 1240

ON (Date): 14 May 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)-2

(b)(6)-2

WILLIAM

PRE-TRANSFUSION

TEMP. 98.2 | PULSE 105 | BP 117/64

DATE OF TRANSFUSION: 14 May 03

TIME STARTED: 1230

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	98.7	114	128/72

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filler Set, and I.V. solutions to the Blood Bank

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [ ] NO
- [ ] YES (Specify)

(b)(6)-2

SEX: M

WARD: ICU2

MEDCOM - 5777

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I - REQUISITION

COMPONENT AEQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

TYPE AND SCREEN

- [X] CROSSMATCH

DATE REQUESTED: 14-May 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE. IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

(2 Nephrectomy

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

(b)(6)-2

TIME VERIFIED

(b)(6)-2

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.
1260423 14May03	423
	PATIENT NO.

DONOR	RECIPIENT
ABO A	ABO AB
Rh Pos	Rh Pos

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
N/A	Comp IS 37° AHG

PREVIOUS RECORD CHECK:

- [X] RECORD
- NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 14May03

REMARKS:

Hy P8 282

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* V 1055 ON *(Date)* 14May 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and

(b)(6)-2

(b)(6)-2 LT, AN

PRE-TRANSFUSION

TEMP. 98.2 PULSE 105 BP 12/64

DATE OF TRANSFUSION

TIME STARTED 1130

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, First, middle, grade, rank, ; hospital or medical facility)

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.4	107	165

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures
4. Do NOT discard unit Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

(b)(6)-2

SEX M

(b)(6)-2

MEDCOM - 5778

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

*U S GPO 1993-0-356 139180643

PATIENT NAME
PATIENT NO. # (b)(6)-4
PATIENT TYPE AB POS

NSN 7540-00-634-4159

UNIT NO 1260425
UNIT TYPE A POS
UNIT EXPIRATION 14MAY03

COMPATABILITY TECH [illegible] (IS) (37°) (AHG)

VENT TRANSFUSION

ell

REQUESTING PHYSICIAN (Print)
Dr. (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE
CBSW & ureteral tear

☐ Rh IMMUNE GLOBUUN
☐ OTHER (Specify)

DATE AND HOUR REQUIRED

I have collected a blood specimen on the below named patient verified the name and ID No of the patient and verified the specimen tube label tc be correct

VOLUME REQUESTED (If applicable)
1UNIT ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)
NONE

SIGNATURE OF VERIFIER
(b)(6)-2

REMARKS

IF PATIENT IS FEMALE, IS THERE HISTORY OF
RhIG TREATMENT? DATE GIVEN:
HEMOLYTIC DISEASE OF NEWBORN? N/A

9MAY03

TIME VERIFIED
0800

SECTION II – PRE-TRANSFUSIONTESTING

UNIT NO
1260425
14MAY03

TRANSFUSION NO. (b)(6)-4
PATIENT NO.

TEST INTERPRETATION
ANTIBODY SCREEN: NA
CROSSMATCH: Comp IS AHG

PREVIOUS RECORD CHECK:
☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST
(b)(6)-2

DONOR
ABO A
Rh POS

RECIPIENT
ABO AB
Rh POS

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUE... ATE 9MAY03

REMARKS:

#644P8510

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECT (b)(6)-2

AT (Hour) 0900 ON (Date) 9MAY03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature)
(b)(6)-2 LT, AN

(b)(6)-2 SSG 91WMC

PRE-TRANSFUSION
TEMP. 97.4 PULSE 91 BP 110/47

DATE OF TRANSFUSION 9 MAY 03
TIME STARTED 0905

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED
1030 / 9 MAY 03

☒ NONE ☐ SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
97.2 (A)	82	104/48

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present. Keep intravenous line open
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
☐ NO ☐ YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE
(b)(6)-2 LT, AN

PATIENT IDENTIFICATION—USE EMBOSSER [For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility]

SEX M

WARD ICU-2

(b)(6)-4

MEDCOM - 5779

BLOOD OR BLOOD COMPONENT TRANSFUSION

PATIENT NAME [redacted]
PATIENT NO.
PATIENT TYPE AB POS

1640883

UNIT NO. 1640883
UNIT TYPE APOS
UNIT EXPIRATION 14MAY

COMPATABILITY TECH MOZ

ES 37° A+6

NENT TRANSFUSION

I Blood

REQUESTING PHYSICIAN (Print)
DR [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE
GSW ō ureteral damage

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

☐ OTHER (Specify)

DATE AND HOUR REQUIRED
ASAP

VOLUME REQUESTED (If applicable)
1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)
NA

SIGNATURE OF VERIFIER [redacted] LT, AN

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? NA

DATE VERIFIED
9MAY03

TIME VERIFIED
0900

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
14MAY03
1640883

TRANSFUSION NO. [redacted]

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp ES AHG

PREVIOUS RECORD CHECK:
☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR
ABO A
Rh POS

RECIPIENT
ABO AB
Rh POS

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 9MAY0

REMARKS:

646P1623

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND [redacted]

AT (Hour) 1020 ON (Date) 9MAY03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) [redacted] SSO 9MAY03

2nd [redacted] LT, AN

PRE-TRANSFUSION
TEMP. 97.2 PULSE 84 BP 103/63

DATE OF TRANSFUSION: 9MAY03
TIME STARTED: 1035

POST-TRANSFUSION DATA

AMOUNT GIVEN _____ ML

TIME DATE COMPLETED: 9MAY2003 1200

INTERRUPTED

REACTION ☑ NONE ☐ SUSPECTED 97.1(A), P-86, BP 110/51

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER _____

OTHER DIFFICULTIES (Equipment, clots, etc.)
☐ NO ☐ YES (Specify) _____

SIGNATURE OF PERSON NOTING ABOVE [redacted] LT, AN

PATIENT IDENTIFICATION. USE EMBOSSER (For typed or written entries give NAME. Last, first, middle; rank/rate; hospital number and name of facility.)

[redacted]

SEX: M

WARD: ICU-2

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 5780