KPJ KLANG SPECIALIST HOSPITAL

NURSING SERVICES
BLOOD/ BLOOD PRODUCT TRANSFUSION CHECKLIST

Name :
MRN :
D.O.B :
Sex :
Ward :
Bed No :
Date :

A. ADMINISTRATION OF BLOOD COMPONENTS

CHECK PATIENT'S IDENTIFICATION

DETAIL	PATIENT'S FOLDER (√-IF CORRECT)	BLOOD REQUEST FORM (√-IF CORRECT)
NAME		
MRN		
I/C NUMBER		
D.O.B		

B. PRE TRANSFUSION SCREENING

PRE TRANFUSION CHECKLIST

PRE TRANSFUSION SCREENING	DATE REQUEST	YES	NO
CONSENT SIGNED BY PATIENT			
CONSENT SIGNED FOR HIV TEST			
HIV SCREENING			
VDRL SCREENING			
HEPATITIS B SCREENING			
OTHERS			

CONFIRM BLOOD PRODUCT COMPATIBILITY CHECKLIST

BLOOD/ BLOOD PRODUCT	DETAILS	FIRST VERIFIER (DOCTOR/ MEDICAL OFFICER)		SECOND VERIFIER (MEDICAL OFFICER/ UNIT MANAGER/ SRN)	
		YES	NO	YES	NO
COMPATIBILITY OF BLOOD GROUP					
COMPATIBILITY OF BLOOD RHESUS TYPE					
DONOR/ PACK NUMBER					
EXPIRY DATE					
VOLUME OF BLOOD COMPONENTS					
STATUS OF SCREENING TEST (DATE)					
NAME					
SIGNATURE					

C. VERIFIED BY TWO PERSONS

VERIFICATION PRIOR TO TRANSFUSION BY TRAINED NURSES

DETAIL	REMARK	FIRST VERIFIER		SECOND VERIFIER	
		YES	NO	YES	NO
IDENTIFY PATIENT CORRECTLY- NAME & MRN/ DOB/ IC NUMBER					
BLOOD TRANSFUSION REQUEST FROM AVAILABLE					
CONSENT AVAILABLE					
SCREENING TEST AVAILABLE					
CONFIRM BLOOD PRODUCT COMPATIBILITY					
EXPIRY DATE					
PACK NUMBER					
NAME					
SIGNATURE					

D. TRANSFUSION PROCEDURE

DATE OF TRANSFUSION	
TIME COMMENCE TRANSFUSION	
TIME OF COMPLETION	
TRANSFUSION FLOW RATE	
REACTION (IF ANY)	
REMARKS	

MONITOR VITAL SIGN AS BASELINE, 15 MINUTES, 30 MINUTES AND FOLLOWED BY HOURLY UNTIL COMPLETE BLOOD TRANSFUSION. RECORD IN OBSERVATION CHART