**Pre-Hospital Emergency Transfusion Record**

The blood components have NOT been crossmatched and their use is the sole responsibility of the requesting clinician

**Indication for Transfusion**:

Suspected Injuries: …………………………………………………..

…………………………………………………………………………………..

Mechanism…………………………………………………………………

……………………………………………………………………………………

Died at scene: YES/ NO

Hospital / Mortuary conveyed to:……………………………………………

Pre-hospital Provider:……………………………………………………

**Subsequent Units**

**2 3 4 5 6 7 8**

 Within 1 hour of opening or data logger green

 Suitable blood group (O RBC, group AB or A FFP)

 Unit undamaged

 Unit within expiry date

**Pre transfusion Checklist:**

**Unit One**:

* Box Sealed
* Suitable blood group (O RBC, group AB or A FFP)
* Unit undamaged.
* Unit within expiry date.

**Patient Demographics:** (complete or write unknown)

Surname………………………………………………………………….

Forename………………………………………………………………..

Amb. service CAD No………………………………………………………….

Hospital ID (if known) ………………………………………………

DOB (or est age) …………………….. Gender: Male/Female/Other

Female of child-bearing potential: Yes/ No

 This patient has verbally consented to transfusion of emergency products / components and understands the risks, benefits and possible alternatives to this intervention.

 This patient is unable to provide consent because they are unconscious / lack capacity (delete as appropriate) and must be informed of the transfusion prior to hospital discharge. No evidence has been found to suggest that they would object to a transfusion of blood components / products

Clinician Name: ……………………………………………..………… Clinician Signature: ……………………………………………..…………

**Prescription:**

**Return of unused blood components**

I can confirm that all other units have remained within the transit box at all times with the lid securely fastened (opened only to remove products prescribed above)

Clinician Name……………………………………………………………………………………. Clinician Signature………………………………………………………………………..

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Unit | Date | Time | Product | Unit number | Clinician Name | Clinician Signature |
| One |  |  |  |  |  |  |
| Two |  |  |  |  |  |  |
| Three |  |  |  |  |  |  |
| Four |  |  |  |  |  |  |
| Five |  |  |  |  |  |  |
| Six |  |  |  |  |  |  |
| Seven |  |  |  |  |  |  |
| Eight |  |  |  |  |  |  |