



Pre-Hospital Emergency Transfusion Record

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

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

Indication for Transfusion:

Suspected Injuries:

 Mechanism.....

 Died at scene: YES/ NO
 Hospital / Mortuary conveyed to:.....
 Pre-hospital Provider:.....

Pre transfusion Checklist:

Unit One:

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

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

Prescription:

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

Confirmation of Blood Component Handling and Return

I acknowledge that red cell components contained within this transit box may be O RhD positive and are being transfused for a patient of unknown blood group.

Clinician Name..... Clinician Signature..... Date

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..... Date