The observations recorded here are the minimum monitoring required.
Use the NEWS (National Early Warning Score) chart
if deviations from baseline are noted.

Affix addressograph here or write patient details:
Forename:
Surname:
Date of Birth:
Hospital/NHS no:

S P E C I M E N

IF AUTHORISING MORE THAN ONE UNIT OF RED CELLS – IS THE PATIENT GOING TO BE RE-ASSESSED BETWEEN UNITS?

Pre-administration checklist – **MUST BE COMPLETED** by the person administering immediately prior to the transfusion, **AT THE PATIENT'S SIDE**	Unit 1	Unit 2	Unit 3
• Patient is wearing identification (ID) band, or approved alternative is in use	☐	☐	☐
• Patient identifiers on ID band are correct (confirmed by PPI* where possible)	☐	☐	☐
• Patient identifiers on compatibility label match those on ID band and AWTR**	☐	☐	☐
• Donation number on compatibility label and component are identical	☐	☐	☐
• Patient's blood group is compatible with component blood group	☐	☐	☐
• Component is within expiry date/time	☐	☐	☐
• Visual check of component completed (leaks, discolouration, clumping)	☐	☐	☐
• Component is correct (i.e. red cells, platelets, FFP, or cryoprecipitate)	☐	☐	☐
• Concomitant medication administered (if required)	☐	☐	☐
• Specific requirements met (if any indicated)	☐	☐	☐
*Positive Patient Identification **All Wales Transfusion Record — **Sign to confirm completion of checklist:**			

Unit 7

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 8

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 9

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

GIG CYMRU NHS WALES

ALL WALES TRANSFUSION RECORD

This is a permanent record of transfusion and must be filed or scanned

Patient Details

Affix addressograph here or write patient details

Hospital/NHS №: Assigned sex at birth:
Forename: Surname:
Address: Date of birth:

Hospital/Unit:
Ward/Dept:
Consultant:
Weight (kg): [Essential for TACO risk management]

Consent to Transfusion

– to be completed and signed by the authoriser prior to authorising blood component transfusion

Informed and valid consent for transfusion should be completed for all patients who will likely, or definitely, receive a transfusion[1].
Confirm if the following have taken place: [1]SaBTO 2020

1. Reason for transfusion, intended benefits, risks and alternatives have been discussed with the patient* Yes ☐ No ☐
2. The patient has been offered a '*Receiving a Blood Transfusion*' Patient Information Leaflet (PIL) *[see QR code below]* Yes ☐ No ☐
3. The right to withdraw consent at any point and possible consequences of this has been discussed with the patient Yes ☐ No ☐
4. The points above, and the outcome of the discussion, are documented in the patient's healthcare record Yes ☐ No ☐
5. The patient has consented to having a blood transfusion Yes ☐ Not possible ☐

* or parent/guardian/appointed advocate

If 'No' to any of the above, state the reason: ______

Signature:______ **Print Name:**______ **Date:**______

Cymraeg *English*

Specific Transfusion Requirement

– to be completed by the authoriser prior to authorising blood component transfusion

Useful resource – Blood Assist:

Does the patient have specific transfusion requirements?	Yes ☐ No ☐ *If Yes, please indicate:*	Irradiated ☐	CMV Negative ☐	HLA matched ☐

Transfusion Associated Circulatory Overload (TACO) Risk Assessment

– to be completed and signed by the authoriser prior to authorising blood component transfusion

- Does the patient have a diagnosis of 'heart failure' congestive cardiac failure (CCF), severe aortic stenosis, or moderate to severe left ventricular dysfunction?
- Is the patient on a regular diuretic?
- Does the patient have severe anaemia?

- Is the patient known to have pulmonary oedema?
- Does the patient have respiratory symptoms of undiagnosed cause?

- Is the fluid balance clinically significantly positive?
- Is the patient receiving intravenous fluids (or received in previous 24 hours)?
- Is there any peripheral oedema?
- Does the patient have hypoalbuminaemia?
- Does the patient have significant renal impairment?

Table adapted from the SHOT TACO checklist, accessible here:

Following assessment, was a risk of TACO identified? Yes ☐ No ☐
If Yes, clearly document in the patient's healthcare record details of the risk assessment and any intervention/actions to manage the risk.

Signature:______ **Print Name:**______ **Date:**______

Note: The person administering the blood component transfusion must ensure that the consent to transfusion and TACO risk assessment above have been completed. If there are any concerns regarding either of these, they must be resolved with the person making the decision to transfuse/authorising the transfusion prior to commencing administration.

Transfusion Reactions:

Acute reactions to blood components may manifest during the transfusion or up to 24 hours after; refer to local protocols for management of reactions, and seek expert advice as appropriate (e.g., haematologist, transfusion practitioner, transfusion laboratory).

It is recommended that patients discharged within 24 hours of transfusion are given a contact card with 24-hour access to clinical advice.

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if deviations from baseline are noted.

Affix addressograph here or write patient details:

Forename:

Surname:

Date of Birth:

Hospital/NHS no:

Pre-administration checklist – **MUST BE COMPLETED** by the person administering immediately prior to the transfusion, **AT THE PATIENT'S SIDE**

	Unit 1	Unit 2	Unit 3
• Patient is wearing identification (ID) band, or approved alternative is in use	☐	☐	☐
• Patient identifiers on ID band are correct (confirmed by PPI* where possible)	☐	☐	☐
• Patient identifiers on compatibility label match those on ID band and AWTR**	☐	☐	☐
• Donation number on compatibility label and component are identical	☐	☐	☐
• Patient's blood group is compatible with component blood group	☐	☐	☐
• Component is within expiry date/time	☐	☐	☐
• Visual check of component completed (leaks, discolouration, clumping)	☐	☐	☐
• Component is correct (i.e. red cells, platelets, FFP, or cryoprecipitate)	☐	☐	☐
• Concomitant medication administered (if required)	☐	☐	☐
• Specific requirements met (if any indicated)	☐	☐	☐
*Positive Patient Identification **All Wales Transfusion Record **Sign to confirm completion of checklist:**			

IF AUTHORISING MORE THAN ONE UNIT OF RED CELLS – IS THE PATIENT GOING TO BE RE-ASSESSED BETWEEN UNITS?

Unit 1

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number:

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 2

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 3

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

SPECIMEN

The observations recorded here are the minimum monitoring required.
Use the NEWS (National Early Warning Score) chart
if deviations from baseline are noted.

Affix addressograph here or write patient details:

Forename:

Surname:

Date of Birth:

Hospital/NHS no:

Pre-administration checklist – **MUST BE COMPLETED** by the person administering immediately prior to the transfusion, **AT THE PATIENT'S SIDE**

	Unit 1	Unit 2	Unit 3
• Patient is wearing identification (ID) band, or approved alternative is in use	☐	☐	☐
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• Component is within expiry date/time	☐	☐	☐
• Visual check of component completed (leaks, discolouration, clumping)	☐	☐	☐
• Component is correct (i.e. red cells, platelets, FFP, or cryoprecipitate)	☐	☐	☐
• Concomitant medication administered (if required)	☐	☐	☐
• Specific requirements met (if any indicated)	☐	☐	☐
*Positive Patient Identification **All Wales Transfusion Record **Sign to confirm completion of checklist:**			

IF AUTHORISING MORE THAN ONE UNIT OF RED CELLS – IS THE PATIENT GOING TO BE RE-ASSESSED BETWEEN UNITS?

Unit 4

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 5

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 6

Indication Code (NBTC) *[see QR code]* or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?
				Yes☐ No☐

Specific Requirements or Instructions: Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:

Authoriser — Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

SPECIMEN