# WHOLE BLOOD TRANSFUSION CHECKLIST

*COMPLETE THIS CHECKLIST FOR EACH UNIT **TRANSFUSED** POST EVENT*

| LOCATION OF TRANSFUSION: | DATE: |
|---|---|
| WHOLE BLOOD UNIT # | |

1. DONOR PRESCREENED FOR TRANSFUSION TRANSMITTED DISEASE (TTD) MARKERS WITH FDA APPROVED TESTS WITHIN LAST 90 DAYS?

YES_____ NO_____

2. DONORS SCREENED AT TIME OF COLLECTION USING RAPID TESTS FOR:

MALARIA YES_____ NO_____
HIV YES_____ NO_____
HBV YES_____ NO_____
HCV YES_____ NO_____
RPR YES_____ NO_____

3. RAPID TEST RESULTS AVAILABLE PRIOR TO PRODUCT RELEASE?

YES_____ NO_____

4. DONORS SCREENED USING **DD572** & CURRENT SOP ? YES_____ NO_____

5. BLOOD TUBES COLLECTED AT THE TIME OF COLLECTION FOR FOLLOW UP WITH FDA TTD TESTING YES_____ NO_____

6. INTERNATIONAL SOCIETY FOR BLOOD TRANSFUSION (ISBT) LABELS USED YES_____ NO_____

7. TUBES AND A COPY OF **DD572** FORWARDED TO BSD? YES_____ NO_____

8. UNIT ACCOUNTED FOR IN TMDS? YES_____ NO_____

9. WAS COMPONENT THERAPY AVAILABLE WHEN FWB WAS GIVEN YES_____NO_____

10. PLEASE PROVIDE ANY INFLUENCING FACTORS THAT PREVENTED YOU FROM FOLLOWING THE SOP FOR THIS TRANSFUSION EVENT (IF APPLICABLE):

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*INDIVIDUAL COMPLETING CHECKLIST*

| | |
|---|---|
| **Print Name** | **Signature** |

**This checklist is to be kept on file for a minimum of one (1) year. Forward a copy to BSD with corresponding samples for <u>Every</u> unit of Whole Blood <u>transfused</u>.**

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