RECORD OF DECISION TO TRANSFUSE

Patient's name:	DOB:	Identification number:

Component required:	**Indication:**	**Specific requirements:**	**Consider alternatives:**
☐ Red blood cells ☐ Platelets ☐ FFP ☐ Cryoprecipitate ☐ Granulocytes Other (please state):	☐ Symptomatic anaemia ☐ Bleeding ☐ Prophylaxis Other (please state):	☐ Irradiated ☐ CMV negative ☐ HLA selected Other (please state):	☐ Oral and/or IV Iron ☐ Folic acid ☐ Tranexamic acid Other (please state):

NOTE: Consider single-unit red blood cell transfusions for adults (or equivalent volumes calculated by body weight for children or adults with low body weight) with no active bleeding.[1] An Hb rise of 10g/L, per unit, only applies as an approximation for a 70–80 kg patient.[2] **Re-assess your patient after each unit transfused.**

I have explained the risks, benefits and alternatives to transfusion and obtained verbal consent from the patient or legal guardian. ☐ **YES** ☐ **NO**	Written information provided? ☐ **YES** ☐ **NO** If no, please state reason:

Verbal consent **has not** been obtained. Therefore I will:

☐ complete the trust paperwork; and

☐ discuss with the patient and provide information retrospectively (when applicable).

I confirm that in my professional opinion this transfusion is indicated.

Name (please PRINT):	Designation (please PRINT):	Signature:	Date:

Version 1 Effective 31/12/2018

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