Standard Operating Procedure (SOP) Pre-transfusion Patient Assessment and Documentation

This SOP details the process for **pre-transfusion patient assessment and documentation**, which includes verifying patient identity, reviewing medical history and transfusion indications, conducting baseline vital signs and laboratory tests, assessing for potential transfusion risks and allergies, obtaining informed consent, and accurately documenting all findings and consent details. The goal is to ensure patient safety and transfusion efficacy by thoroughly evaluating suitability and maintaining comprehensive records prior to blood product administration.

1. Purpose

To establish a standardized process for the assessment and documentation of patients prior to blood transfusion to maximize patient safety and the effectiveness of transfusion therapy.

2. Scope

This SOP applies to all healthcare professionals responsible for prescribing and administering blood and blood products in [Facility Name].

3. Responsibilities

- **Physicians:** Review transfusion indications, explain risks and benefits to the patient, and obtain informed consent.
- **Nurses:** Perform patient assessment, record vital signs and laboratory findings, verify identity, and complete all documentation.
- **Laboratory Staff:** Ensure accurate and timely laboratory test results required for transfusion.

4. Procedure

1. **Patient Identity Verification**
    - Confirm patient identity using at least two identifiers (e.g., full name and date of birth) against medical records and wristband.
2. **Medical History Review**
    - Review and document relevant medical history, including previous transfusions, reactions, and current indications for transfusion.
3. **Baseline Assessment**
    - Obtain baseline vital signs (temperature, pulse, blood pressure, respiratory rate, oxygen saturation).
    - Review and document pertinent laboratory test results (e.g., hemoglobin, hematocrit, crossmatch, ABO/Rh type).
4. **Transfusion Risk Assessment**
    - Assess and document history of allergic or transfusion reactions, comorbidities, pregnancy history (if applicable), and current medications.
    - Identify any transfusion contraindications or heightened risks.
5. **Informed Consent**
    - Discuss indication, risks, benefits, and alternatives of transfusion with patient (and/or legal representative).
    - Obtain and document written informed consent prior to transfusion.
6. **Documentation**
    - Record all assessments, findings, and completed consent in the patient's medical record and transfusion chart.
    - Ensure accuracy and completeness of documentation prior to commencing transfusion.

5. Documentation Checklist

Task	Completed (Yes/No)	Initials	Date/Time
Patient Identity Verified			

Medical History Reviewed			
Baseline Vital Signs Recorded			
Lab Results Reviewed			
Risk Assessment Completed			
Consent Obtained and Documented			
All Findings Documented in Chart			

6. References

- [Insert relevant national transfusion guidelines]
- [Insert hospital policies and procedures]
- [Insert other reference standards]

7. Appendices

- Appendix A: Example Pre-transfusion Assessment Form
- Appendix B: Informed Consent Template