BLOODSAFE MEMORIAL HOSPITAL
INVESTIGATION

FACILITATOR INSTRUCTIONS

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ELEARNING AUSTRALIA
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THE OBJECTIVE

Purpose of the Activity

This activity uses an investigative approach to explore how errors can occur during the transfusion of a blood component. Learners are presented with a patient folder containing clinical documentation, laboratory results, transfusion records, and other relevant information.

Working in groups, learners must determine:

- What type of error has occurred?
- What factors contributed to the error?
- What mitigation strategies could prevent future errors?

The focus of the activity is on developing critical thinking, clinical reasoning, and patient safety awareness rather than finding a single correct answer.

As the facilitator, your role is to:

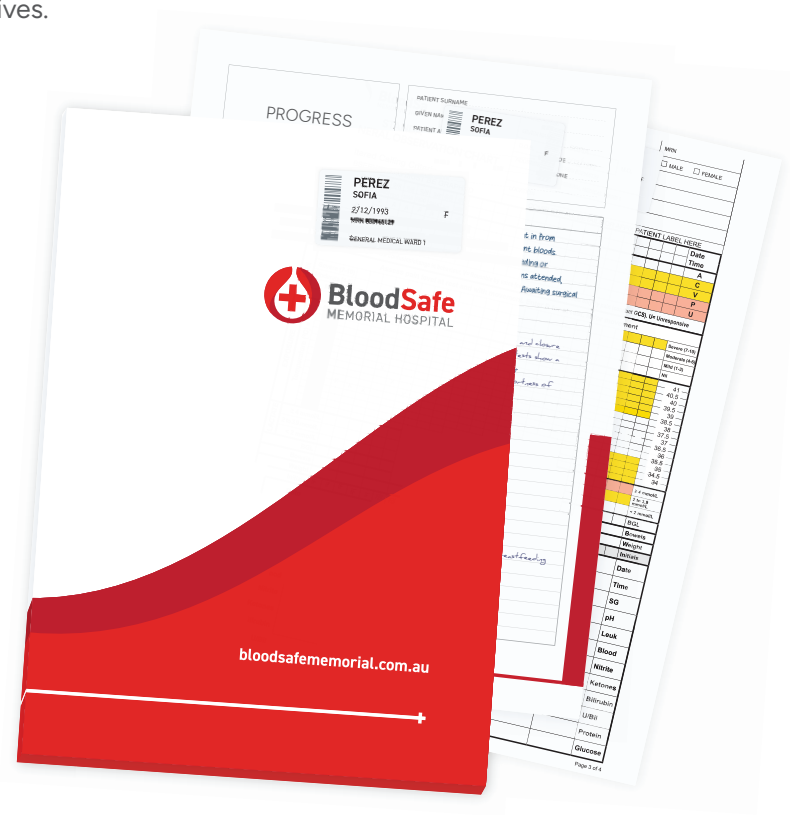
- guide discussion
- encourage participants to use evidence from the patient file to support their conclusions
- promote discussion
- encourage consideration of prevention and quality improvement strategies
- ensure all participants have an opportunity to contribute.

Avoid confirming or rejecting responses immediately.
Instead, use probing questions to help learners
justify their reasoning and explore alternative perspectives.

Length of Activity

20 minutes for investigating and completing the provided report.

30 minutes of discussion time.



HOW TO PLAY

Running the Activity

Break up learners into small groups of approximately 3-6 individuals.

Provide each group with a patient folder. You may choose to use different case scenarios for each group or the same patient for all groups. Explain the purpose of the activity.

Suggested introduction:

> "You have been provided with a patient file containing information related to a transfusion error. Your task is to review the available information and determine what occurred, how it happened, and what actions could prevent a similar event in the future. Be prepared to explain your reasoning using evidence from within the file."

Allow learners approximately 20 minutes to review the patient file and complete their report before discussion.

Running the discussion

Discussion should take approximately 30 minutes and should focus on 4–6 key discussion questions. Facilitators can use the provided questions as a guide, selecting or adapting questions based on the case and learners' needs. The facilitator's role is to encourage discussion, critical thinking, and reflection rather than provide answers. Learners should be prompted to support their conclusions using evidence from the patient's file, consider alternative perspectives, explore contributing factors, and identify opportunities for prevention and improvement.



Find out more about our Clinical Transfusion Practice courses here

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DISCUSSION QUESTIONS

Incident identification and clinical impact

1. What was the error that has occurred in this case?
2. What was the outcome for the patient?
3. Are there any other diagnoses or adverse events that should be considered?
4. Are there any ongoing risks to the patient that need to be considered?

Patient blood management

5. Was the transfusion appropriate? Why or why not?
6. Were there any other blood management strategies that could have been considered to avoid a transfusion?
7. How can clinicians balance the risk of transfusions against the perceived benefits when deciding to transfuse?
8. Were relevant transfusion policies, guidelines or patient blood management protocols followed? If not, why?

Origin of the error

9. Where in the transfusion process did the error occur? Could it have been avoided?
10. What checks or verification processes could have interrupted the error?
11. Are there existing safeguards to prevent this error that failed or were bypassed?

Contributing factors and root cause analysis

12. What are the key contributing factors?
13. What contributing factors may have increased the likelihood of the event occurring?
14. Were there any assumptions that may have been made that contributed to the event?
15. Was this a human error, systems error, communication failure, or a combination of factors? Why?
16. What workload, staffing fatigue, or environmental factors may have contributed to this event?
17. Were there any breakdowns in handover, documentation or verbal communications between teams or shifts?

Investigation and reporting

18. Is there any additional information that you would have liked to collect following this event?
19. How should this incident be reported?

Prevention and risk reduction

20. What mitigation strategies would have had the greatest impact?
21. What actions could have prevented this event from occurring?
22. What role could education and training play in avoiding future incidents or mistakes?

Recommendations and organisational learning

23. What recommendations would you make following this event?
24. How could this event be used as a learning opportunity for staff?
25. What barriers might exist to implementing these improvements?
26. What lessons could be learned from this case

FACILITATOR EVALUATION FORM

Please scan the QR code below to complete an evaluation survey on this activity. Thank you.

Facilitator

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BLOODSAFE MEMORIAL HOSPITAL
INVESTIGATION

PATIENT FILES
SOFIA PEREZ

BloodSafe
MEMORIAL HOSPITAL

*All cases and patient information presented in this investigation game are entirely fictional and have been created for educational purposes.

BloodSafe
MEMORIAL HOSPITAL

Haemovigilance Department
Floor 3, Zone A
BloodSafe Memorial Hospital
1572 Littleton Road,
Lyra Falls SA 5088 AUSTRALIA

bloodsafememorialhospital.com.au

Internal Communication to Clinical Staff:

Due to recent hospital demands and a surge of adverse events relating to blood transfusions, you have been selected to assist in a case review. All relevant patient information has been provided. Once you have reviewed the information, you will need to complete the incident investigation report and present your findings to the Haemovigilance Committee.

As you work through this case you will need to answer the following questions:

1. **Identify the adverse event that has occurred**

2. **Analyse the contributing factors**
   Consider all elements that may have led to the adverse event, including:
   - Human factors
   - System or process issues
   - Communication breakdowns

3. **Recommend mitigation strategies**
   - Identify practical actions that could prevent a similar event in the future.

Work through this case as you would with any clinical investigation, document your findings clearly and concisely. The purpose is not only to identify errors but to understand how and why they occurred. There may not always be an obvious single answer – your reasoning is just as important as your conclusions.

Should you need any assistance during this investigation, contact your haemovigilance lead.

Kind regards,

BBergamont

Belinda Bergamont
BloodSafe Memorial Hospital
Haemovigilance Committee

INCIDENT INVESTIGATION

PATIENT SURNAME

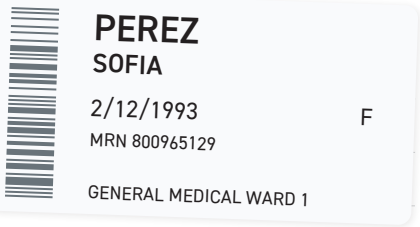
GIVEN NAME(S)

MRN

DATE OF BIRTH /

SEX

ROOM NUMBER



INVESTIGATOR NAME/S

IDENTIFY THE ADVERSE EVENT THAT HAS OCCURRED

ANALYSE THE CONTRIBUTING FACTORS

RECOMMEND MITIGATION STRATEGIES

PATIENT REGISTRATION

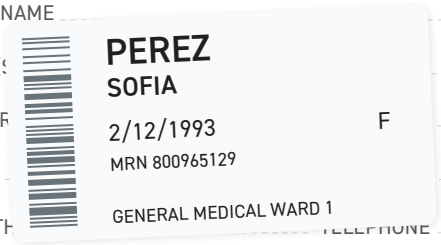
PATIENT SURNAME

GIVEN NAME(S

PATIENT ADDR

DATE OF BIRTH

ROOM NUMBER



OFFICE USE ONLY - ADMISSION INFORMATION

Admit Date: 09/08/2026 | Admit Time: 09:45 | Visit Number: 1

Primary Consultant: B FAUX | Admit Location: GEN MED WARD 1 | Bed No.: 5

Soursce of Referral: PRE-ADMISSIONS | Inter-Hospital Transfer - From:

Service: SURGERY 1 | Visit Reason: IDA

Election: [X] Public [ ] Private | Funding Source:

(Overnight) / Day Admit | Re-admit in Last 7 Days: Yes / (No) | __No. of Days C/F | Related Admission: Yes / (No)

Medicare No.: 4 1 6 7 9 3 2 2 2 | Reference No.: 1 | Expiry Date: 09/28

Date of Birth: 02/12/1993 | Age: 32 | Country of Birth: AUSTRALIA

Marital Status: [ ] Never Married [X] Married/De Facto [ ] Widowed [ ] Divorced [ ] Separated [ ] Unknown/Not Stated

Maiden Name: | Other/Previous Names:

RESIDENTIAL ADDRESS

42 PINE ROAD

Suburb: SOMEWHEREVILLE

State: SA | Postcode: 5084

Home Phone: ( )

Mobile Phone: 0441 419 0992

Business Phone:

POSTAL / TEMPORARY ADDRESS

Suburb:

State: | Postcode:

Home Phone: ( )

Mobile Phone:

Business Phone:

I would like to receive SMS notification of future appointments (where SMS is available) [X] Yes [ ] No

Mobile phone number to receive SMS notification: 0441 419 0992

Preferred Language / Dialect: ENGLISH

Interpreter Required: [ ] Yes [X] No | Interpreter Type: [ ] Female [ ] Male [ ] Either

Indigenous Status: [X] Not Aboriginal or TSI [ ] Aboriginal [ ] Not Stated / Unknown [ ] TSI [ ] Aboriginal and TSI

Religion (optional): | Clergy Visit: Yes / No | Ethnicity:

MAIN ACCOMMODATION/HOUSING IN THE LAST THREE MONTHS

[X] Private Residential
[ ] Independent Unit (part of retirement village or similar)
[ ] Residential Aged Care or Hostel
[ ] Homeless - Boarding / Rooming House
[ ] Homeless - No usual residence
[ ] Homeless - Shelter/Refuge
[ ] Unknown - Unable to determine
[ ] Other:

CONTACT 1 (eg. Person Responsible / Next of Kin)

Relationship to Patient: WIFE

Last Name: PEREZ

First Name: BELINDA

Address: 42 PINE ROAD

Suburb: SOMEWHEREVILLE

State: SA | Postcode: 5084

Home Phone: ( )

Mobile: 04218 529 0116

Business Phone: ( )

CONTACT 2 (eg. Contact for this Visit)

Relationship to Patient:

Last Name:

First Name:

Address:

Suburb:

State: | Postcode:

Home Phone: ( )

Mobile:

Business Phone: ( )

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PATIENT REGISTRATION

PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRESS

DATE OF BIRTH / /

ROOM NUMBER



PATIENT DIRECTIVE

Do you have an Advance Care Directive / Plan or Resus Plan? ☐ Yes ☒ No

If yes, please select from list below

- ☐ Advance Care Directive
- ☐ Anticipatory Direction
- ☐ Palliative Care Plan
- ☐ Resus Plan - 7 step pathway
- ☐ Enduring Power of Guardianship
- ☐ Interstate ACD
- ☐ Ulysses Agreement
- ☐ Other:
- ☐ Medical Power of Attorney
- ☐ Statement of Choices
- ☐ Facility Form

(Do not record Enduring Power of Attorney as an Advanced Care Directive).

Has an original certified copy been provided for this attendance? ☐ Yes ☐ No

HEALTH CONCESSION CARD DETAILS

Pension/Healthcare Card/Commonwealth Seniors Healthcare Card:

Card Number: Expiry Date:

DVA Card Number: DVA Card Colour: ☐ Gold ☐ White ☐ Orange ☐ Blue

PBS Safety Net Number: Expiry Date:

Private Health Fund: ☐ Yes ☒ No ☐ Hospital Cover

Fund Name: Membership Number:

Other Insurer: ☐ Yes ☒ No Details:

COMPENSABLE VISITS ONLY

☐ Work Injury Date of Injury:

Claim Number:

Employer Name:

Employer Address:

Contact Phone No.: ( )

☐ Motor Vehicle Accident Date of Injury:

Claim Number:

State:

CARE TEAM REFERRAL

GP DETAILS

Name: N/A

Practice Name:

Address:

Suburb:

State: Postcode:

Phone Number: ( )

REFERRER DETAILS

Name:

Practice Name:

Address:

Suburb:

State: Postcode:

Phone Number: ( )

Consent to Notify GP this Visit: ☒ Yes ☐ No ☐ Not Asked ☐ Unable to Answer

PATIENT DECLARATION

I Sofia Perez certify that the information provided on this form is true and accurate.

SIGNATURE: SPerez DATE: 9/8/26

Relationship to Patient: ☒ Self ☐ Parent ☐ Guardian ☐ Other:

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PATIENT SURNAME

GIVEN NAME(S

PATIENT ADDR

DATE OF BIRTH

ROOM NUMBER

PEREZ
SOFIA
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

PATIENT HEALTH QUESTIONNAIRE

Answer all questions and tick boxes *Please tick*

INFORMATION

Date Form Completed: 7/8/2026 Weight: 60 Height: 171cm
Who Completed the Form: Sofia Perez Body Mass Index (BMI):
Admission Reason: Hernia repair ☑ Nurse to Verify Name, DOB and Address

ANAESTHESIA

Have you had an anaesthetic before? If yes, list all operations including date/year and hospital: C-Section 2024 - Blood Safe Memorial	☒ Yes ☐ No
Have ☐ you, or any ☐ blood relative ever had any problems with anaesthetics? If Yes, list all operations including date/year and hospital:	☐ Yes ☒ No ☐ Unknown

How far can you walk without stopping?
☐ Round the house ☐ Only 1–2 blocks
☒ Regular walking and exercise

What stops you from walking further?
☐ Shortness of breath ☐ Joint Pain ☐ Chest Pain
☐ Leg Pain ☐ Other:

Do you have any ☐ Neck Stiffness or ☐ Difficulty Opening your Mouth?	☐ Yes ☒ No
☐ Heartburn ☐ Reflux ☐ Indigestion ☐ Hiatus Hernia ☐ Stomach or Duodenal Ulcers	☐ Yes ☒ No
☐ Gastric Band ☐ Is Band Inflated? ☐ Yes ☐ No ☐ Weight Loss Surgery	☐ Yes ☒ No
Have you had steroids such as Prednisolone, Cortisone or Hydrocortisone in a tablet or through your vein in the last 3 months? When? Reason:	☐ Yes ☒ No
In the last two weeks have you had ☐ Cold ☐ Flu ☐ Sore Throat ☐ Chest Infection	☐ Yes ☒ No
Have you had COVID-19 in the last 8 weeks?	☐ Yes ☒ No
Are you or could you be pregnant?	☐ Yes ☒ No
Are you breastfeeding?	☐ Yes ☒ No
Do you have any questions or concerns about the anaesthetic, procedure or operation that you would like to discuss? For example: needle phobia, anxiety Details:	☐ Yes ☒ No

ALLERGIES / SENSITIVITIES

Do you have a known allergy / sensitivity to latex or rubber? What reaction?	☐ Yes ☒ No
Do you have any allergies / sensitivities to medications, foods, or skin sensitivities? Details:	☐ Yes ☒ No

ENDOCRINE / ORGAN FUNCTION

Do you have Diabetes treated with ☐ Insulin ☐ Tablets ☐ Non-Insulin Injection ☐ Diet-Controlled?	☐ Yes ☒ No
What are your usual blood sugar levels? Most recent HbA1c value? Details:	☐ Yes ☒ No
Thyroid Disease? Details:	☐ Yes ☒ No

GASTROINTESTINAL CONDITIONS

History of/currently have ☐ Bowel Surgery ☐ Inflammatory Bowel Disease Details:	☐ Yes ☒ No
History of/currently have ☐ Liver Disease ☐ Jaundice ☐ Pancreatitis Details:	☐ Yes ☒ No

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GENERAL MEDICAL WARD 1

PATIENT HEALTH QUESTIONNAIRE

Answer all questions and tick boxes *Please tick*

RESPIRATORY		
Do you have troublesome shortness of breath? When?	☐ Yes	☒ No
☐ Chronic Bronchitis ☐ Emphysema ☐ Tuberculosis ☐ Persistent Cough ☐ COAD/COPD	☐ Yes	☒ No
Do you have Asthma? How often? Triggers:	☐ Yes	☒ No
Do you use a puffer, inhaler, nebulizer (eg. Ventolin)? What? How often (e.g. daily/weekly/monthly)?	☐ Yes	☒ No
Have you ever been in hospital for your Asthma? Where? When?	☐ Yes	☒ No
☐ Snore loudly? ☐ Have you been observed to stop breathing while asleep? ☐ Fall asleep easily during the day while sitting/driving?	☐ Yes	☒ No
☐ Sleep Apnoea ☐ Use CPAP ☐ Sleep Studies Where? When? **Bring CPAP machine into hospital when you are admitted**	☐ Yes	☒ No
Any respiratory testing in the last 3 years? Where? When?	☐ Yes	☒ No
Do you attend a Respiratory clinic or see a Respiratory Specialist? Where? Who? Last Appointment:	☐ Yes	☒ No

CARDIAC		
Do you have or take treatment to prevent high blood pressure?	☐ Yes	☒ No
☐ Heart Failure ☐ AF (Atrial Fibrillation) ☐ Rheumatic Fever ☐ Heart Murmur	☐ Yes	☒ No
☐ Chest Pain or Angina ☐ Chest Tightness ☐ Palpitations How often? Tiggers?	☐ Yes	☒ No
Have you ever had a heart attack? When?	☐ Yes	☒ No
Have you ever had heart surgery? Details:	☐ Yes	☒ No
☐ Pacemaker ☐ Implantable Defibrillator ☐ Heart Stent/s When inserted? Type: **Bring information card if available**	☐ Yes	☒ No
Any heart investigations (ie: Echocardiogram, Angiogram) in the last 3 years? What? Where? When?	☐ Yes	☒ No
Do you attend a Heart Clinic or see a Cardiologist? Where? Who? Last Appointment:	☐ Yes	☒ No

GENITOURINARY CONDITIONS		
Kidney Disease	☐ Yes	☒ No
☐ Dialysis Where? When (circle)? M T W Th F Sat ☐ Renal Failure, Acute ☐ Renal Failure, Chronic ☐ UTI, History of	☐ Yes	☒ No
Do you see a Renal Specialist? Where? Who? Last Appointment:	☐ Yes	☒ No

TEETH		
☐ Loose Teeth ☐ Chipped Teeth ☒ ~~Capped~~ / Crowned Teeth? Where? *Upper top*	☒ Yes	☐ No
Do you have dentures? Upper: ☐ Partial ☐ Full Lower: ☐ Partial ☐ Full	☐ Yes	☒ No

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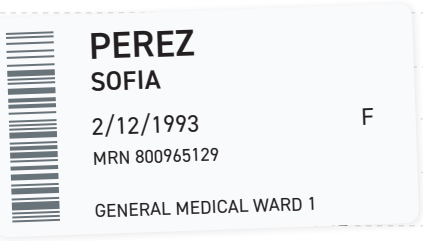
PATIENT SURNAME

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ROOM NUMBER



PATIENT HEALTH QUESTIONNAIRE

Answer all questions and tick boxes

Please tick

INFECTIOUS DISEASES		
Have you travelled overseas in the last 21 days? Where?	☐ Yes	☑ No
In the last 4 weeks, have you had exposure to a communicable disease (e.g. Measles/Chickenpox/Whooping Cough/Hepatitis/COVID)? Details:	☐ Yes	☑ No
In last six months, have you been in an interstate hospital? Details:	☐ Yes	☑ No
In the last 12 months have you ☐ Been in an overseas hospital or residential care facility? ☐ Received overseas medical treatment (i.e dialysis or day surgery)?	☐ Yes	☑ No
Have you ever been told that you have ☐ MRSA ☐ VRE ☐ CRE ☐ Other: Informed by: Where/When?	☐ Yes	☑ No
NEUROLOGICAL		
☐ Stroke ☐ Mini Stroke (TIA) ☐ Blackout ☐ Funny Turn ☐ Seizure / Epilepsy How many or often? When was your last one?	☐ Yes	☑ No
☐ Muscular Dystrophy ☐ Muscular/Mytonic Dystrophy ☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Myasthenia Gravis ☐ Motor Neurone Disease	☐ Yes	☑ No
Do you have pain? ☐ Short term (less than 3 months) ☐ Long term (more than 3 months) Details:	☐ Yes	☑ No
COGNITION / PERCEPTION / PSYCHOSOCIAL		
Do we need to book an interpreter? Language/Dialect: ☐ Male ☐ Female ☐ Either	☐ Yes	☑ No
☐ Hearing Problem ☐ Vision Problems Details: **Bring your hearing aids and glasses to hospital on admission**	☐ Yes	☑ No
☐ Dementia ☐ Alzheimer's Disease ☐ Short Term Memory Loss	☐ Yes	☑ No
Intellectual Disability? Details:	☐ Yes	☑ No
Do you have cultural and/or spiritual issues we need to know about? Describe:	☐ Yes	☑ No
Do you and your family identify as ☐ Aboriginal ☐ Torres Strait Island or ☐ Both?	☐ Yes	☑ No
Do you have an Advance Care Directive? **Bring original certified copy (preferred) OR original document**	☐ Yes	☑ No
Can you sign your own consent? If not, who can?	☑ Yes	☐ No
PERIPHERAL VASCULAR/OTHER		
☐ Blood Clots ☐ Deep Vein Thrombosis (DVT) ☐ Clot in Lung ☐ Other:	☐ Yes	☑ No
☐ PAD (Peripheral Artery Disease) ☐ PVD (Peripheral Vascular Disease) ☐ Thrombophlebitis/Phlebitis ☐ Lymphoedema/Oedema ☐ Varicose Veins	☐ Yes	☑ No
☐ Chemotherapy ☐ Radiotherapy Date Treatment Commenced: Details:	☐ Yes	☑ No
SKIN CONDITIONS		
☐ Bed Sore ☐ Pressure Wounds	☐ Yes	☑ No
☐ Psoriasis ☐ Dermatitis ☐ Other:	☐ Yes	☑ No
Painful areas on your skin? Describe:	☐ Yes	☑ No

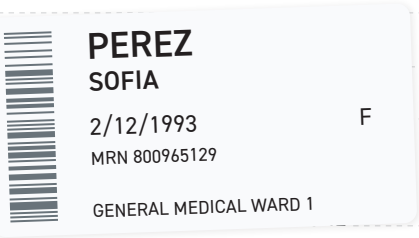
PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRESS

DATE OF BIRTH /

ROOM NUMBER



PATIENT HEALTH QUESTIONNAIRE

Answer all questions and tick boxes

Please tick

CONNECTIVE TISSUE / MOBILITY		
☐ Arthritis ☐ Osteoarthritis ☐ Rheumatoid Which Joints?	☐ Yes	☒ No
Muscular disease or weakness in the arms or legs? Details:	☐ Yes	☒ No
Other connective tissue disorders? (eg. Scleroderma or Lupus) Details:	☐ Yes	☒ No
☐ Artificial Joints ☐ Implants Details:	☐ Yes	☒ No
☐ Walking Frame ☐ Stick ☐ Wheelchair **Bring your walking aids into hospital when you are admitted**	☐ Yes	☒ No

HAEMATOLOGY		
☐ History of Anaemia ☐ Currently Anaemic	☐ Yes	☒ No
Excessive bleeding or bruising (or family member with this problem)? Details:	☐ Yes	☒ No
Other blood disorders (eg. Thalassemia, Sickle Cell)? Details:	☐ Yes	☒ No
Blood transfusion? When:	☐ Yes	☒ No
Have you had a hospital admission for any health problems (excluding operations) in the last 3 years? Details:	☐ Yes	☒ No
Other serious illness/hereditary diseases not mentioned? Details:	☐ Yes	☒ No

MENTAL HEALTH		
☐ Anxiety ☐ Depression ☐ Bi-polar ☐ Other:	☐ Yes	☒ No

FALLS SCREEN		
Have you had any falls in the last 6 months? Details:	☐ Yes	☒ No

ALCOHOL, TOBACCO AND DRUGS		
Do you drink alcohol? How many days a week? 2 Average glasses per day? 1-2	☒ Yes	☐ No
☐ Cigarettes ☐ Vaporisers ☐ E-Cigarettes How many per day? First cigarette minutes after waking	☐ Yes	☒ No
Thinking of quitting?	☐ Yes	☐ No
Have you ever smoked in the past? How many per day? How many years? When did you quit?	☐ Yes	☒ No
Do you use recreational drugs? (eg. Marijuana, Ecstasy, Cocaine) What? How often? Last used:	☐ Yes	☒ No

DIETARY REQUIREMENTS		
Do you have swallowing difficulties?	☐ Yes	☒ No
Do you require thickened fluids?	☐ Yes	☒ No
Fluid Restrictions ☐ 1 litre ☐ 1.5 litre	☐ Yes	☒ No
Do you require a specific diet? Details: Vegetarian	☒ Yes	☐ No

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GENERAL MEDICAL WARD 1

PATIENT HEALTH QUESTIONNAIRE

Answer all questions and tick boxes *Please tick*

ELIMINATION AND CONTINENCE

☐ Incontinence ☐ Frequency ☐ Urgency ☐ Nocturia ☐ Burning ☐ Pain ☐ Urostomy ☐ Catheter	☐ Yes	☒ No
Wears Pads? Other:	☐ Yes	☒ No
☐ Constipation ☐ Diarrhoea ☐ Incontinence ☐ Colostomy ☐ Ileostomy	☐ Yes	☒ No
Laxative use? Details:	☐ Yes	☒ No

HOME SITUATION

☒ Home with Others Who? (please list) Wife and Son
☐ Home Alone ☐ Nursing Home ☐ Homeless
☐ Community Support Details:

Have they been informed of admission?	☒ Yes	☐ No
Are you a carer for others? 18m Son	☒ Yes	☐ No

What arrangements have been made for their ongoing care? Wife will care for

ADDITIONAL INFORMATION

Your contact phone number between 3pm and 7pm of the business day before your surgery

Mobile: 0491 919 099 Home: 8676 5311 Work:

Email address: s.perez@gmail.com Occupation: Teacher

Do you require a sick certificate? ☒ Yes ☐ No ☐ Centrelink ☐ Workcover ☐ Other

PRIMARY CONTACT PERSON

Name of Primary Contact Person: Belinda Perez

Relationship: Wife Phone Number: 0418 529 011

DAY SURGERY PATIENTS ONLY

If you are having day surgery you cannot drive for 24 hours after your anaesthetic. You must have a responsible adult to accompany you home and stay with you for the first 24 hours following anaesthesia.

Responsible Adult Name: Phone Number:

QUESTIONS OR COMMENTS (PATIENT USE ONLY)

PATIENT HEALTH QUESTIONNAIRE

PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADD

DATE OF BIRTI

ROOM NUMBEI



Answer all questions and tick boxes *Please tick*

MEDICATIONS / DRUGS		
List ALL regular and occasional medications and tablets, herbal supplements, over the counter preparations, puffers, sprays, eye drops and injections or attach an up to date drug list from your pharmacist or GP. **This is IMPORTANT as some medications may affect your surgery.**		☐ Yes ☒ No
Do you take any blood thinners (ie. Aspirin, Warfarin, Clopidogrel), Anti-inflammatories or Herbal medicines?		☐ Yes ☒ No
Do you use your own pill box? If yes, who fills it?		☐ Yes ☒ No
Do you have a Webster pack? Pharmacy that fills pack:	Phone Number:	☐ Yes ☒ No

REGULAR MEDICATIONS (Please copy name and dose from packet) List all Regular Medication or provide copy of list and attach.	Strength (eg. per tablet)	How many at each time of day?			
		Morning	Midday	Evening	Night

LIST OCCASIONAL MEDICATIONS

Bring your medications to hospital on day of admission in chemist pack or original bottles/boxes.

Reviewed by: Method: ☐ Phone ☐ Face to Face

Name: Designation:

SIGNATURE: Date:

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GENERAL MEDICAL WARD 1

Monday 9th August

Bed	Patient Name	DOB	MRN	Specialty	Situation	Background	Assessment	Recommendation
1	Rose Klien	16/07/1951	800425698	Upper GI	Epigastric Pain	PMHX: Hypertension, high cholesterol, type 2 diabetes	1x Assist, Clear fluids, 2x PIVC day 2	PPI infusion, IVF, for CT abdo
2	Jose Sanchez	11/12/1959	800416985	Gen Med	Hyponatremia	PMHX: Depression, recent diarrhoeal illness	PIVC x1, Na 120 mmol 8/8, altered calling criteria HR yellow zone >120 red zone >130	strict FBC, Fluid restricted (<800m/L), continue salt tablets, monitor for seizure activity, daily electrolytes
3	Pam Beetle	12/10/1981	800472564	Respiratory	Infective exacerbation of asthma	PMHX: Asthma	DROPLET precautions awaiting respiratory swab, independent, PIVC x 1 day 2, CXR shows left lower lobe consolidation	resp swab pending, continue inhalers, IVabs, repeat CXR mane
4	Pearl Wyle	20/02/1928	800473651	Geriatrics	UTI	PMHX: recurrent UTIs, ischemic heart disease, asthma. high cholesterol, dementia	from nursing home PIVC x 1 day 0, 2x assist, falls risk GCS 13 (baseline), not for resuscitation	for 24 hours of IVabs, encourage fluid intake, pressure area care, aim for discharge back to nursing home on PO abs 10/8
5	Sofia Perez	2/12/1993	800965129	Surgery 1	Hernia Repair	PMHX: nil	from pre admissions clinic for work up for IDA, PIVC x1	1 unit of red cells. t/f to surgical ward when bed available
6	Kevin Stephens	16/11/1965	800459871	Gastroenterology	Melaena	PMHX: Hypertension, GORD	HB 75 g/L with GP, Vitally stable, stool chart	NBM, for repeat bloods and group and hold. For 1 unit of red cells, ? endoscopy mane
7	Betty Cook	13/01/1938	800417259	Renal	AKI	PMHX: Depression, anxiety, hypertension, high cholesterol, IBS	from nursing home, 2x assist, not for resuscitation, PIVC day, IDC	strict fluid balance chart, IVF, ? renal u/s, repeat bloods mane
8								
9	Trevor Stephenson	26/01/1965	800476358	Gastroenterology	Upper GI Bleed	PMHX: Asthma, Type 2 diabetes	HB 70g/L 1/7 ago. Assoc fatigue. 1x Melaena overnight. Stool chart	NBM, for repeat bloods and group and hold

PATHOLOGY RESULTS

Sofia Perez

DOB: 2/12/1993
Sex: Female
MRN: 800965129

	06/02/2024 @ 0600	10/08/2026 @ 0800	Reference Ranges
Haemoglobin	120	95	115-165 g/L
HCT	0.39	0.37	0.37-0.47 L/L
Red cell count	4.6	4.5	4.4-5.8 x1012/L
MCV	81	78	80-100 fL
MCH	26	24	26.5-33.0 pg
MCHC	318	314	310-360 g/L
RDW	15.1	15.6	11.5-15.0
White Cell Count	4.0	6.89	3.5-11.0 109/L
Neutrophils	3.45	3.41	1.7-7.0 109/L
Lymphocytes	2.5	2.63	1.5-4.0 109/L
Monocytes	0.58	0.56	0.1-0.8 109/L
Eosinophils	0.20	0.24	0.04-0.44 109/L
Basophils	0.2	0.1	0.0-0.2 109/L
Platelets	238	520	150-400 x 109/L

	06/02/2024 @ 0600	10/08/2026 @ 0800	Reference Ranges
Blood Group	O	O	
RhD	Positive	Positive	

	06/02/2026 @ 0600	10/08/2026 @ 0800	Reference Ranges
Iron		15	5.0-30.4 umol/L
Transferrin		3.01	1.8-3.5 g/L
Saturation		10	15-45 %
Ferritin		11	15-200 ug/L

PATHOLOGY RESULTS

Sofia Perez

DOB: 2/12/1993
Sex: Female
MRN: 800965129

	06/02/2026 @ 0600	10/08/2026 @ 0800	Reference Ranges
Sodium	138	141	135-145 mmol/ L
Potassium	4.0	4.4	3.5-5.2 mmol/L
Chloride	98	103	95-110 mmol/L
Bicarbonate	25	27	22-32 mmol/L
Urea	4.5	5.0	3.0-7.0 mmol/L
Creatinine	78	58	45-90 umol/L
EGFR	>90	>90	(> 59) mL/min/1.73m2
Calcium	2.20	2.35	2.10-2.60 mmol/L
Phosphate	1.20	1.13	0.75-1.50 mmol/L
Albumin	42	40	35-50 g/L
ALP	50	68	30-110 U/L
Bilirubin	8	9	3-20 umol/L
GGT	19	16	5-35 U/L
AST	25	21	5-30 U/L
ALT	25	21	5-35 U/L
LD	140	132	120-250 U/L

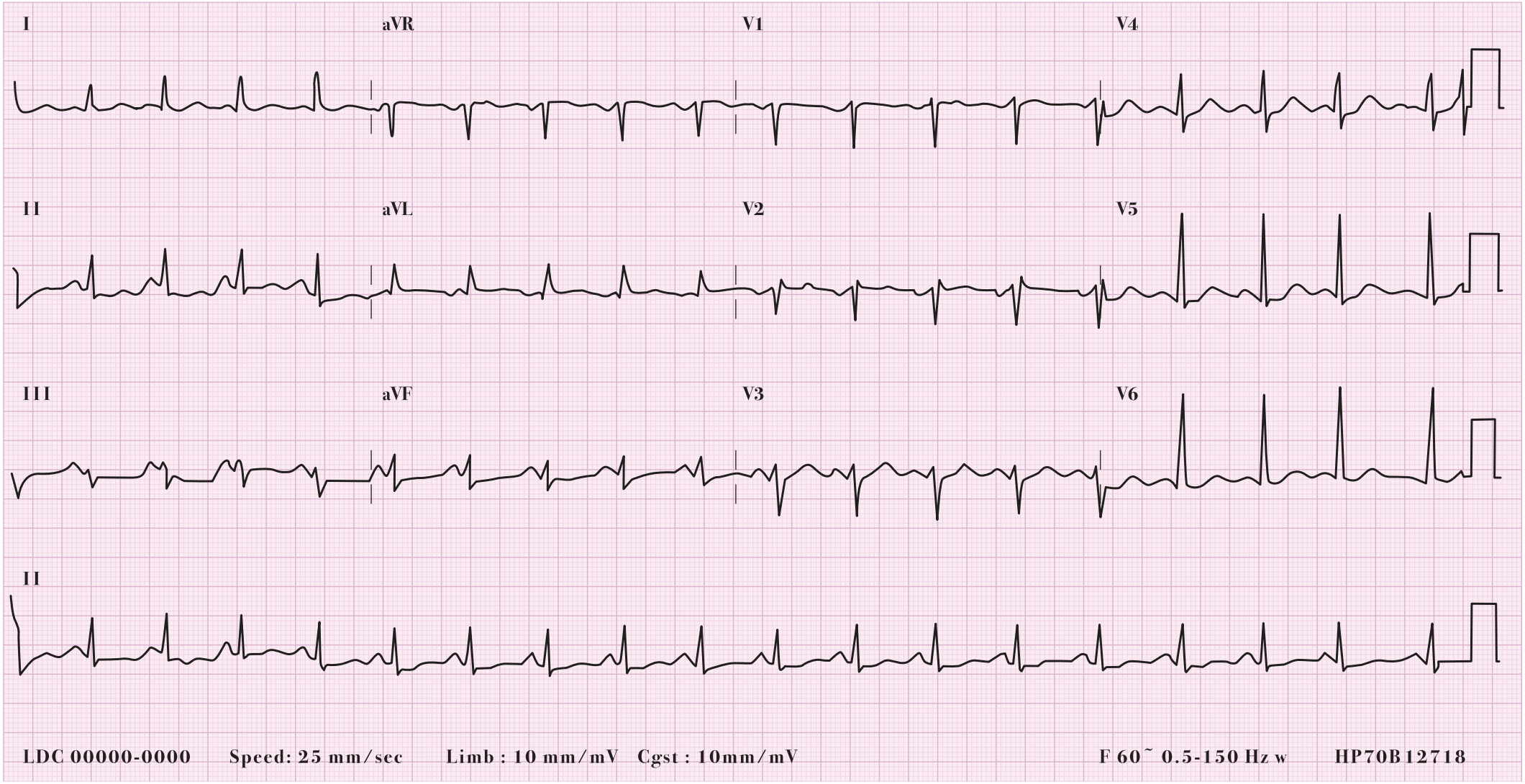
PR	140
QRSD	82
QT	324
QTc	438

--AXIS--

P	84
QRS	16
T	-32

PEREZ
SOFIA
2/12/1993 F
MRN 800965129

GENERAL MEDICAL WARD 1



PROGRESS NOTES

PATIENT SURNAME

GIVEN NAM

PATIENT A

DATE OF E

ROOM NUMBER



Date / Time	Notes
09/08/2026 @ 1000	NURSING: New admission under the surgical team. 33-year-old female sent in from pre-admissions clinic with a new diagnosis of iron deficiency anaemia in recent bloods. Denies any shortness of breath, fatigue or lethargy. Denies any signs of bleeding or unexplained bruising. Alert and orientated, independent with ADL's. Vital signs attended, all within normal parameters, afebrile and pain free. Orientated to the ward. Awaiting surgical review and plan. I. Ferris RN
09/08/2026 @ 1100	SURGICAL WARD ROUND: 33-year-old female sent in from pre-admissions clinic. Awaiting repair and closure of a right incisional hernia in 5 weeks' time. Her most recent blood tests show a new iron deficiency anemia that will require correction before surgery. Patient states that she is normally fit and well. Denies any fatigue, shortness of breath, lethargy or palpitations.
	PMHX: C-section 2024
	Medications: Nil
	Allergies: Nil
	Social History: Lives at home with wife and 18-month-old baby boy – not currently breastfeeding 1-2 glasses of wine on the weekends Denies smoking or illicit drugs

PROGRESS NOTES

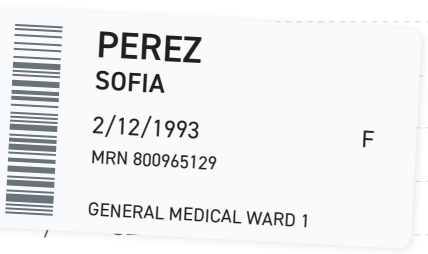
PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRESS

DATE OF BIRTH

ROOM NUMBER



Date / Time	Notes
	Physical Examination: Neurological: alert and orientated Cardiovascular: HR regular, well perfused both centrally and peripherally, nil murmurs present, capillary refill <3 seconds, denies any chest pain or palpitations. Respiratory: Bilateral lung sounds clear on auscultation. No wheeze or crackles. RR normal, talking in full sentences, denies any shortness of breath at rest or on movement. Normal exercise tolerance. Gastrointestinal: lower quadrant pain on palpation, small incisional hernia noted, dull, non-radiating. C-section scar noted. Denies any nausea, vomiting, diarrhea or constipation. Denies any blood in stools or melaena. Last menstrual period 14 days ago. Denies heavy bleeding or clots. Tolerating normal diet and fluids –recently vegetarian. Skin: nil abnormalities. Denies any unexplained bruising or bleeding. **Differential:** Iron deficiency anaemia for optimisation before surgery **Plan:** For 1 unit of red cells Repeat blood tests in the morning ECG PIVC Eat and drink as tolerated Gastroenterology consult for investigation of new iron deficiency Discuss with consultant to move hernia repair up to this week whilst in the hospital and has a post-op bed – will need to be consented. G Ore Surgical registrar

PROGRESS NOTES

PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRE

DATE OF BIRTH

ROOM NUMBER



Date / Time	Notes
09/08/2026 @1050	NURSING: ECG attended. Vitals signs are all within normal parameters. PIVC patent. I Ferris RN
09/08/2026 @ 1100	Sofia consented for a blood transfusion. Risks and benefits are explained. Nil further questions or concerns S Pang Surgical intern
09/08/2026 @ 1315	NURSING: 1 unit of red cells has been requested from the transfusion laboratory. I Ferris RN
09/08/2026 @ 1350	NURSING: Baseline vital signs attended. All within normal parameters. Afebrile. 1 unit of red cells commenced over 2 hours as per medical order. Patient identity, pack, and prescription checked by two registered nurses. Sofia educated on possible side effects and advised to use the call bell to report any changes. I Ferris RN
09/08/2026 @ 1405	NURSING: Observations attended as per blood transfusion policy. Febrile at 37.8 all other vital signs within normal parameters. Transfusion stopped. Surgical team contacted to review. I Ferris RN
09/08/2026 @ 1411	SURGICAL REVIEW: Request to review Sofia due to a temperature rise of 1oc during a transfusion of red cells.
	A: patent, own, nil swelling or angioedema present
	B: spontaneous, equal air entry bilaterally, nil wheeze, crackles or stridor
	C: warm and well perfused centrally and peripherally, HR 80 bpm – regular
	D: alert and orientated. GCS 15
	E: nil rashes noted

PROGRESS NOTES

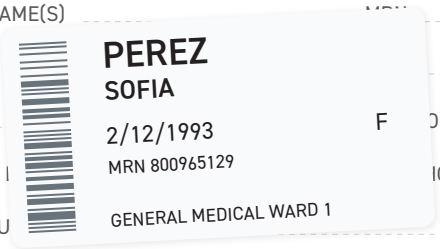
PATIENT SURNAME

GIVEN NAME(S)

PATIENT

DATE OF I

ROOM NU



Date / Time	Notes
	Plan:
	1g of Paracetamol STAT
	Restart red cell transfusion at a slower rate over 3 hours
	Increase visual monitoring
	Increase observations to 30 minutes including temperature throughout the remainder of the red cell transfusion
	Please contact me if you have any further concerns or Sofia experiences any further reaction
	G Ore Surgical registrar
09/08/2026 @ 1415	NURSING: paracetamol given as per chart. Red cells recommenced at a slower rate over 3 hours with increased monitoring I Ferris RN
09/08/2026 @ 1445	NURSING: Vital signs rechecked – temperature now 36.8°C. I Ferris RN
09/08/2026 @ 1500	SURGICAL TEAM Open disclosure completed with Sofia. Incident reporting completed - Incident ID 51675. S Pang surgical intern
09/08/2026 @ 1715	NURSING: Red cell transfusion completed. Patient remains vitally stable and afebrile throughout. Nil concerns voiced. F Graed RN
09/08/2026 @ 1800	SURGICAL EVENING ROUNDS: Sofia remains vitally stable and afebrile. Denies any pain. Nil further complications post transfusion. Alert placed in EMR for future transfusions. Booked on the theatre list for closure and repair of her right incisional hernia 12/8. Consent to be completed in the morning with the consultant. G Ore Surgical Registrar

CONSENT TO BLOOD AND BLOOD PRODUCTS

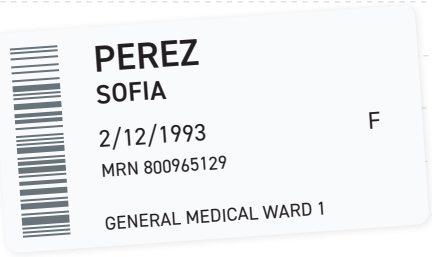
PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRESS

DATE OF BIRTH /

ROOM NUMBER



THIS FORM IS TO BE USED FOR INFUSION OF:

- [x] Red Blood Cells (RBC)
- [ ] Platelets
- [ ] Other (please specify):
- [ ] Fresh Frozen Plasma (FFP)
- [ ] Cryoprecipitate

CLINICAL CONDITION/INDICATION FOR ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS

Iron deficiency anaemia for optimisation before surgery

DURATION OF CONSENT:

- [x] This hospital admission
- [ ] 12 months (recurrent transfusion/infusion to manage chronic illness)

Consent for blood and blood products is valid for 12 months from date of consent **unless** the clinical condition changes OR consent is withdrawn by the patient.

PATIENT DECLARATION

1. I understand that a blood or blood product transfusion/infusion may be a necessary part of my treatment.
2. I have been provided with a **patient transfusion/infusion information** brochure in a language I can understand.
3. I acknowledge that the doctor has discussed the potential benefits, risks and appropriate alternative treatments.
4. I understand that I am receiving a biological product, therefore, it comes with potential risks and complications.
5. I have had the opportunity to ask questions and request further information related to transfusion/infusion and that my specific queries and concerns have been answered.

PATIENT'S FULL NAME (PRINT) Sofia Perez

PATIENT'S SIGNATURE SPerez DATE 9/8/26 TIME 10:55

SUBSTITUTE DECISION MAKER RESPONSIBLE FOR GIVING CONSENT IF NOT THE PATIENT

Risks and benefits of the anaesthetic have been discussed with the patient and relevant consent discussions are documented within this form and within the patient's medical record should additional space be required.

SUBSTITUTE DECISION MAKER'S FULL NAME (PRINT)

RELATIONSHIP TO PATIENT

SUBSTITUTE DECISION MAKER'S SIGNATURE DATE TIME

DECLARATION OF DOCTOR/HEALTH PRACTIONER

I have explained the following information to the patient and/or their substitute decision maker:

- risks and benefits associated with transfusion/infusion
- appropriate alternative treatments
- risks of non-transfusion/infusion

DOCTOR/HEALTH PRACTITIONER'S FULL NAME (PRINT) Gregory Ore

POSITION/TITLE Surgical Registrar

DOCTOR/HEALTH PRACTITIONER'S SIGNATURE GOre DATE 09/08/26 TIME 1055

INTERPRETER'S DECLARATION (IF APPLICABLE)

I declare I have interpreted the dialogue between the patient and doctor/health practitioner to the best of my ability and have advised the doctor/health practitioner of any concerns about my interpreting of this dialogue.

INTERPRETER'S FULL NAME (PRINT) SPECIFIC LANGUAGE REQUIRED

AGENCY NAATI NUMBER

INTERPRETER'S SIGNATURE DATE TIME

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BLOOD COMPONENT ADMINISTRATION CHECKLIST

PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRES

DATE OF BIRTH

ROOM NUMBER



1 Preparation for transfusion	Outcome	If 'NO' complete the following action
Staff and equipment are available	☑ OK ☐ NO	Ensure these are sufficient and transfusion is being performed in a clinical area
Informed consent discussion has occurred and is documented	☑ OK ☐ NO	Confirm that the patient understands the procedure and consent has been obtained
Prescription is valid	☑ OK ☐ NO	Obtain valid prescription
IV access is patent	☑ OK ☐ NO	Ensure IV access is patent and sufficient
Patient ID band is attached and correct – ask the patient or carer if possible	☑ OK ☐ NO	Ensure correct patient ID band is attached
Record baseline observations in the 60 minutes before transfusion	☑ OK ☐ NO	Observe and record temperature, pulse, respirations, blood pressure, and any rashes
2 Blood component collection	**Outcome**	**If 'NO' complete the following action**
Check patient identification, component type and special requirements details are present	☑ OK ☐ NO	Take documented patient identification, component type and special requirements details to collect pack
Check special requirements (if any) on the prescription have been met	☑ OK ☐ NO	Do not proceed and contact Transfusion Service Provider
Check documented patient details and compatibility label attached to pack are identical	☑ OK ☐ NO	Do not proceed and contact Transfusion Service Provider
3 Patient, prescription and pack check	**Outcome**	**If 'NO' complete the following action**
Inspect pack for: • Leaks or splits • Clots, discolouration, cloudiness • Expiry date and time	☑ OK ☐ NO	Do not proceed and contact Transfusion Service Provider. Note: Fresh frozen plasma (FFP) and cryoprecipitate will have two expiry dates; one when frozen and another date once thawed. Use the date that expires first.
Identical patient, component and compatibility labels: • Patient first and family names • Patient DOB • Patient MRN/URN • ABO blood group compatibility • Blood donation number	☑ OK ☐ NO	Involve the patient, if possible. If any discrepancies arise, do not proceed and contact Transfusion Service Provider or senior nurse or medical officer.
Identical patient and prescription: • Patient first and family names • Patient DOB • Patient MRN/URN	☑ OK ☐ NO	Do not proceed and contact Transfusion Service Provider or senior nurse or medical officer
Identical prescription, component and compatibility labels: • Patient first and family names • Patient DOB • Patient MRN/URN • Component type • Special requirements met (if any)	☑ OK ☐ NO	Do not proceed and contact Transfusion Service Provider or senior nurse or medical officer
All above checks were performed uninterrupted by two independent checkers and have been documented. Both must compare and confirm this is the right pack for the right patient.	☑ OK ☐ NO	Do not proceed and perform all above checks again and document

BLOOD COMPONENT ADMINISTRATION CHECKLIST

PATIENT SURNAME
GIVEN NAME(S)
PATIENT ADDRES
DATE OF BIRTH
ROOM NUMBER



PEREZ
SOFIA
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

4 Blood component administration	Outcome	If 'NO' complete the following action
Blood component administration to be started by a person who has completed all checks	☑ OK ☐ NO	Do not proceed and perform all checks before starting administration
Administer component as per prescription specific infusion rates	☑ OK ☐ NO	Confirm blood component specific infusion rates with prescriber. For stable patients start slowly and usually administer: • Red cells: 2–3 hours per pack • Platelets: 30 minutes per pack • FFP: 30 minutes per pack • Cryoprecipitate: 30–60 minutes per dose
Transfusion completed within 4 hours and/or prior to component expiry	☐ OK ☐ NO	Consult senior nurse/medical officer if transfusion likely to take over 4 hours
5 Post-transfusion processes	**Outcome**	**If 'NO' complete the following action**
Ensure patient has received all the prescribed component	☑ OK ☐ NO	Consider clearing IV line with minimum volume of 0.9% sodium chloride solution (normal saline). Exercise caution in at-risk patients, i.e. neonates, infants, patients at risk of circulatory overload.
Monitor patient as required post-transfusion	☑ OK ☐ NO	Monitor patient according to local protocols and clinical indications post-transfusion
Dispose of blood component pack safely if transfusion uneventful	☑ OK ☐ NO	Dispose of blood component pack as per local health service protocols
Complete documentation: • Start and finish dates and times • Blood donation number • Transfusion observations and outcomes in patient records (electronic/paper)	☑ OK ☐ NO	Complete all relevant documentation

Red cell transfusion

For adult, haemodynamically stable, non-bleeding inpatients

Use in conjunction with local guidance and expert advice

Australian Red Cross Lifeblood®

Before you transfuse consider:

- Clinical signs and symptoms of anaemia
- Cause of anaemia and if specific therapy (eg. iron therapy) is available
- Patient's underlying condition and comorbidities
- Response to previous transfusions

Transfuse 1 unit then reassess

- Single unit transfusion is the standard of care for adult, haemodynamically stable, non-bleeding inpatients.
- Additional units should only be prescribed after reassessment and consideration of the Hb and clinical response to transfusion.
- Identify patients at risk of circulatory overload and implement preventative strategies as appropriate. Use a TACO assessment tool.

Clinical condition and supporting evidence	Usually appropriate[1]	May be appropriate[2]	Usually inappropriate
Medical, surgical and obstetric including: • Critical care (TRICC study) • Sepsis (TRISS study) • Haemopoietic SCT (TRIST study)	**Hb < 70 g/L**	**Hb 70–90 g/L**	**Hb > 90 g/L** Liberal transfusion strategies have not demonstrated superior outcomes to restrictive transfusion strategies (in mortality, acute MI, stroke, and short-term health-related quality of life). Each red cell transfusion increases the potential risk for transfusion-associated adverse events.
• Cardiac surgery (TRICS III study)	**Hb < 75 g/L**	**Hb 75–90 g/L**	
• Hip surgery with a history of cardiovascular disease (FOCUS study)	**Hb < 80 g/L**	**Hb 80–90 g/L**	
• Acute myocardial infarction (REALITY and MINT study, AABB Red Cell Transfusion in AMI Guideline)	**Usually appropriate** **Hb < 80 g/L**	**Potential benefit[3]** **Hb 80 to < 100 g/L** Individualise management with expert guidance.	**Usually inappropriate** **Hb ≥ 100 g/L**
• Neurocritical care - acute brain injury[4] (Cochrane Review including HEMOTION, TRAIN and SAHaRA studies)	**Usually appropriate** **Hb < 70–80 g/L**	**Potential benefit[4]** **Hb < 90–100 g/L** Individualise management with expert guidance.	**Usually inappropriate** **Hb ≥ 100 g/L**

1 May not be needed in well-compensated patients or where more appropriate therapy is available e.g. iron replacement in iron deficiency.

2 Considerations include rate of Hb decline, intravascular volume status, risk factors for haemorrhage and need to relieve symptoms and signs of anaemia including shortness of breath, light-headedness, chest pain, hypotension or tachycardia unresponsive to fluid challenge.

3 Potential benefit of red cell transfusion in hospitalised patients with AMI (without haemodynamic instability). May not apply to all patients with AMI. Higher risk for circulatory overload. For more information refer to the AABB & Cardiology Guidelines.

4 Potential benefit of a more liberal Hb threshold of 90–100 g/L in some neurocritically ill patients. Refer to specific guidance based on type of acute brain injury.

References

Carson JL et al. Red blood cell transfusion: 2023 AABB International Guidelines. JAMA. 2023;330(19):1892-1902.

Pagano MB, Stanworth SJ et al. Red Cell Transfusion in Acute Myocardial Infarction: AABB International Clinical Practice Guidelines. Ann Intern Med. 2025.

Rao SV et al. 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2025.

Carson JL et al. Transfusion thresholds and other strategies for guiding red blood cell transfusion. Cochrane Database of Systematic Reviews. 2025.

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BLOOD TRANSFUSION RECORD SHEET

IF TRANSFUSION REACTION OCCURS: Recognise, Respond, Report

1. **Stop** the blood transfusion immediately: **assess** vital signs, **notify** the doctor, change line and maintain IV access
2. **Recheck** patient and pack details - see Bedside Check above
3. **Contact** your local Transfusion Service and if required:
   - complete transfusion reaction report
   - return blood pack with clamped giving set intact in a sealed zip lock plastic bag
   - collect blood/urine specimens as ordered
4. **Monitor** the patient closely
5. **Document** outcome in patient record

PATIENT SURNAM
GIVEN NAME(S)
AREA/WARD

PEREZ
SOFIA
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

BEDSIDE CHECK

WARNING! A responsible qualified staff member must set up every transfusion. In every instance two responsible, qualified persons must perform the bedside check and sign on the reverse side of this sheet along with the relevant pack/product number, declaring that:

1. The patient's identity has been checked against the patient compatibility labels, MO prescription and the attached ID band. Ask the patient (if able) to state and spell their full name and date of birth. Ensure they are all identical and correct.
2. Correct type of blood product. Special requirements have been met. Check against MO prescription, blood component label and patient compatibility labels.
3. The blood group of the patient and donor, the pack/ donation number and the expiry date and time shown on the patient compatibility labels and on the blood component label are identical/compatible.

For further information:
Contact your local Transfusion Service Intranet site.

TRANSFUSION SERVICE

NAME: PEREZ SOFIA	BLOOD PRODUCT RED CELLS
UR:800965129 DOB:2/12/1993	BATCH/DONOR NO. = A0003961
LOCATION GEN MED WARD 1 / PATIENT GROUP O RhD POSITIVE	DONOR GROUP O RhD POSITIVE
XMATCH DATE 07/08/2026 / EXP DATE/TIME 11/08/2026	

REQUIRES: LEUCODEPLETED

PEEL AND STICK INTO PATIENT NOTES

AFFIX LABEL HERE

AFFIX LABEL HERE

AFFIX LABEL HERE

AFFIX LABEL HERE

AFFIX LABEL HERE

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BLOOD TRANSFUSION RECORD SHEET

Ensure that blood products are given only when clearly indicated - when the expected benefits to the patient are likely to outweigh the potential hazards, when in doubt check with senior clinician. For more information refer to National Patient Blood Management Guidelines.

PATIENT SURNAME: PEREZ
GIVEN NAME(S): SOFIA
AREA/WARD: GENERAL MEDICAL WARD 1
2/12/1993 F
MRN 800965129

Transfusion Requirements

Consent documented
☑ Yes ☐ No
Provide patient leaflet (on consent form)

History of Tranfusion Reaction
☐ Yes ☑ No
If yes, ensure documented on alert sheet

Special Product Requirements
☑ None ☐ Irradiated ☐ CMV Neg

Other
☐ Pre-med ☐ Diuretics ☐ Other
If yes - see Medication Chart

URGENCY (circle):
Emergency - Life threatening
Urgent - Clinical deterioration/potential for
(Routine) - Avoid overnight if possible
Overnight (circle): Yes No

Red Cells - Not dictated by Hb alone, but also based on clinical assessment of patient
- **Where indicated, a single unit of red cells, followed by clinical reassessment, is appropriate**
- In iron deficiency, iron therapy is required to replenish stores regardless of whether transfusion is indicated

Hb 95 g/L Associated factors/symptoms SOB Complete indication below:

☐ **Haemorrhage**
Refer to Critical Bleeding Protocol

Adult Medical:
☐ Hb < 70g/L
☐ Hb < 80g/L with Acute Coronary Syndrome (ACS)
☐ Hb 80-100g/L with ACS & benefits outweigh risk
☐ Hb 70-100g/L to relieve significant signs/symptoms anaemia and benefits outweigh risk
☐ BM failure/suppression/chronic transfusion regime
☐ Other (benefits outweigh risk)

Adult Perioperative:
☐ Hb < 70g/L
☐ Hb 70-100g/L acute myocardial ischaemia
☐ Hb 70-100g/L acute cerebrovascular ischaemia
☐ Hb < 80g/L with significant ongoing blood loss or to relieve significant signs/symptoms of anaemia
☑ Other (benefits outweigh risk)

Anti-D (shared care clinic)
Dose of vials: No. of vials:
Date required:
Drs name:
Surgery address:
Phone number:

For Warfarin reversal see guidelines.

Fresh Frozen Plasma (FFP):
(Recommended dosage 10-15mL/kg)
INR APTT
Indication:

Platelets: Pl x10g/L
(1 adult dose = 1 adult pack)
Indication:

Cryoprecipitate:
(1 adult dose = 5 apheresis or 10 whole blood packs)
Fibrinogen level: g/L
Indication:

Other Product:
Indication:

Date	Patient Location	Blood Product	Dose	Route	Rate Max 4hrs	Prescriber			Collector (Sign, Date, Time)	Receiver Clinical Area (Sign, Date, Time)	Serial Number of Pack	Bedside Check Sign & Print Name		Date & Time Started	Date & Time Ended	Volume Given
						Sign	Name	Pager				1	2			
09/08	Geg med	RBC	1 unit	IV	125	GOre	Ore	441	Star 9.8 1300	I Ferris 9.8 1315	A0003961	IF	FG	9.8.26 1350	9.8.26 1715	250

PLEASE USE A NEW SHEET FOR EACH TRANSFUSION EPISODE (eg when the indication and/or laboratory parameters have changed)

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FLUID BALANCE AND PRESCRIPTION CHART

PATIENT SURNAME PEREZ
GIVEN NAME(S) SOFIA
PATIENT ADDRESS
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

DATE 09/08/26

WEIGHT (KG)

SPECIAL INSTRUCTIONS

FOR HOURLY, CUMULATIVE FLUID RECORDING TODAY YES ☐

ADULT
16 YEARS AND ABOVE

FLUID INPUT (mL)

	ORAL FLUID				INTRAVENOUS FLUID AND MEDICINES *INCLUDE VOLUME OF INFUSED MEDICINES								HOURLY AMOUNT IN	GRAND TOTAL IN
	ORAL		ENTERAL		RBC									
	FLUID TYPE		FLUID TYPE		FLUID TYPE		FLUID TYPE		FLUID TYPE		FLUID TYPE			
	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL		
08:00														
09:00														
10:00														
11:00														
12:00														
13:00						250								
14:00														
15:00														
16:00														
17:00														
18:00														
19:00														
20:00														
21:00														
22:00														
23:00														
24:00														
01:00														
02:00														
03:00														
04:00														
05:00														
06:00														
07:00														

FLUID OUTPUT (mL)

URINE		BOWEL								HOURLY AMOUNT OUT	GRAND TOTAL OUT	OVERALL BALANCE	INITIALS
AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL				

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FLUID BALANCE AND PRESCRIPTION CHART

PATIENT SURNAME
GIVEN NAME(S)
PATIENT ADDRESS

PEREZ
SOFIA
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

INDICATIONS - ALL THAT APPLY FLUID BOLUS VOLUME, DEFICIT, ON-GOING LOSS VOLUME, MAINTENANCE, DRUG PRESCRIPTION *MEDICINES MUST BE RECORDED IN DRUG KARDEX **MODEL NAME, SERIAL NUMBER

↓	DATE	TIME	VOLUME	INFUSION FLUID/TYPE	ADDITIVES*	RATE ML/HOUR RANGE	PRESCRIBER'S SIGNATURE	ADMINISTERED BY	CHECKED BY	BATCH/LOT NO. & EXPIRY DATE	PUMP DETAILS**	START TIME	FINISH TIME	VOLUME GIVEN
				A										
				B										
				C										
				D										
				E										
				F										
				G										
				H										

BloodSafe
MEMORIAL PATHOLOGY

Floor 3, Zone 6 BEA Building,
1572 Littleton Road, Lyra Falls SA 5088
bloodsafememorialpathlab.com.au
contact@bloodsafememorialpathlab.com.au

BLOOD PRODUCT REQUEST

(Not for Pre-Transfusion Pathology Requests)

ALL FIELDS ARE MANDATORY

PATIENT DETAILS - Clinical Staff to complete or affix patient label

LAST NAME **PEREZ**

GIVEN NAM **SOFIA**

DATE OF BI 2/12/1993 F

MRN 800965129

GENERAL MEDICAL WARD 1

WEIGHT (KG)

CLINICAL NOTES

URGENT or CRITICAL requests including MTPs MUST be phoned to Blood Bank.

To minimise delays this form must be completed.

PLEASE COMPLETE - This information ensures timely blood supply to correct location

Patient Location/Ward: Gen Med Ward 1

Contact Person: I. Ferris

Date/Time: 09/08/2026 1300

Prescribing Dr: Samuel Pang (Print Full Name)

BLOOD PRODUCT REQUIRED

Order ALL fresh products in Units or mL			Type/Name	Dose/Qty/Vol
Red Cells*	1 unit	Coagulation Factor		
Platelets*		Beriplex		
FFP*		RhD Immunoglobulin		
Cryoprecipitate*	dose(s)	Immunoglobulin		
Cryoprecipitate* paediatric/neonatal	vol	Albumin 5%		
		Albumin 20%		
MTP/Critical Bleed Pack/ECMO		Other		

Special Requirements: Irradiated ☐ CMV Neg ☐ Washed RC ☐ IgA Def ☐ HLA/HPA-Matched ☐

PTS DISPATCH OR BLOOD BANK COLLECTION VERIFICATION

Collected by Hospital Staff ☑

Products and Patient ID checked ☐

Person dispatched or collecting to complete below:

Name: V. Star

Signature: V Star

Date/Time: 9/8/2026 @1300

*OK to be sent by Pneumatic Transport System (PTS)

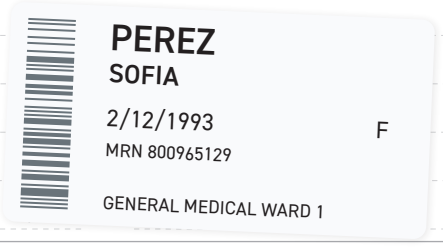
Mandated patient bedside checks must be completed prior to infusion of product.

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MEDICARE CARE NO.

BloodSafe Memorial Pathology
Floor 3, Zone 6 BEA Building
1572 Littleton Road, Lyra Falls SA 5088
bloodsafememorialpathlab.com.au | contact@bloodsafememorialpathlab.com.au

PATIENT SURNAME
GIVEN NAME(S)
PATIENT ADDRESS
DATE OF BIRTH /



REFERRING DOCTOR
(NAME, PROVIDER NUMBER, ADDRESS)
Ore #441

DOCTOR CODE

COPY TO:
(NAME, PROVIDER NUMBER, ADDRESS)

COPY TO:
(NAME, PROVIDER NUMBER, ADDRESS)

HC FACILITY

WARD
Gen Med Ward 1

COLLECTION CENTRE

☐ Public ☐ MBS

CLINICAL NOTES

FASTING YES ☐ NO ☑
PREGNANT YES ☐ Weeks
MEDICATION / TLD

☐ Do not send report to My Health

TEST REQUESTED **URGENT** ☐ PHONE FAX

FBC
UEC + glucose
LFT
Iron studies
CMP
Coagulation studies

DOCTOR'S SIGNATURE AND REQUEST DATE

X GOre 09/08/26

Hospital status of patient at specimen collection or date of service

Private patient in a private hospital	YES ☐	NO ☐
or approved day hospital facility	YES ☐	NO ☐
Private patient in a recognised hospital	YES ☐	NO ☐
Public patient in a recognised hospital	YES ☐	NO ☐
Outpatient of a recognised hosptial	YES ☐	NO ☐

I certify that I collected the accompanying specimen from the above patient whose identity was confirmed by enquiry and/or examination of their ID wristband, and that I labelled the specimen immediately following collection before leaving the patient.

SIGNED: NAME (Print):

PATIENT'S SIGNATURE AND DATE
By this declaration I assign my right to benefits to the Approved Pathology Practitioner who will render the requested pathology service(s).

X / /

LOCATION	INITIALS
C V A I S D	
DATE	TIME

TUBES								URINE				SWABS					SLIDES		CONTAINERS			OTHER
GEL	PLAIN	EDTA	EDTA	FLOX	CITRATE	HEPARIN	TRACE	BACTO	CYTO	24HR	PCR	ORANGE	WHITE	GREEN	RED	PINK	BACTO	CYTO	FAECES	SEMEN	HISTO	DESCRIBE
			9mL																			

Affix patient identification label in this box

UR Number:.....
Surname: .....
Given name: ....
Second given n
D.O.B.: ...../ ...../..... Sex/Gender:.....

PEREZ
SOFIA
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

Attach ADR sticker

See front page for details

As required PRN medicines

Year: 20 26

First prescriber to print patient name and check label correct: GOre ORE

| | | |

OFFICIAL: Sensitive//Medical in confidence

Attach ADR sticker

Allergies and Adverse Drug Reactions (ADR)

☒ Nil known ☐ Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

COMPLETE ALERT SHEET IN MEDICAL RECORD

Sign GOre Print ORE Date 09/08

Affix patient identification label

PEREZ
SOFIA
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

UR Nu ..... pt when
Surnan ..... ble
Given r ..... iers present
Second .....
D.O.B.: ...../...../..... Sex/Gender:.....

First prescriber to print patient name and check label correct: .....

Weight (kg):..... Height (cm):.....

Regular medicines

Year 20..26..... Date and month →

Variable dose medicine

Date | Medicine (print generic name)

Route | Frequency
Prescriber to enter dose time and individual doses

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Drug level
Time level taken
Dose
Prescriber
Time to be given: .....
Time given

Continue on discharge? Yes / No
Dispense? Yes / No
Duration:.....days Qty:.....

Date:

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

Date | Medicine (print generic name)

Route | Dose | Frequency and NOW enter times

Indication | Pharmacy

VTE prophylaxis

Prescriber signature | Print your name | Contact

Mechanical prophylaxis

Prescriber/NI signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration:.....days Qty:.....

Date:

Date | **Warfarin** | Marevan / Coumadin select brand

Route **oral** | Prescriber to enter individual doses | Target INR Range

Indication | Pharmacy

Prescriber signature | Print your name | Contact

AM check
PM check
INR Result
Dose mg mg mg mg mg mg mg mg
Prescriber
1600 Initial 1
Initial 2

Continue on discharge? Yes / No
Dispense? Yes / No
Duration:.....days Qty:.....

Date:

PRESCRIBER MUST ENTER administration times

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration:.....days Qty:.....

Date:

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration:.....days Qty:.....

Date:

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration:.....days Qty:.....

Date:

Pharmaceutical review:

Pharmacist: Date:
Contact: Print your name:
Prescriber's signature: Date:

Recommended administration times
Guidelines only

Morning	Mane	0800			
Night	Nocte			1800 or 2000	
Twice a day	BD	0800		2000	
Three times a day	TDS	0800	1400	2000	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular 8 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

Tick if slow release

SR = Sustained, modified or controlled release formulation.

If scored tablet, then half can be given.

Dose must be swallowed without crushing.

Anticoagulant education record

Medicine:.....

Education
Provided ☐ Declined ☐
Not appropriate ☐

Written Information
Provided ☐ Declined ☐
Written information provided:
CMI ☐ Other: ☐ .....
Signature: .....
Designation: .....Date: .....

Reason for not administering
Codes MUST be circled

Absent	A
Fasting	F
Refused – notify prescriber	R
Vomiting	V
On leave	L
Not available – obtain supply or contact prescriber	N
Withheld – enter reason in clinical record	W
Self administered	S

NOT A VALID ORDER UNLESS LEGIBLE

Medication

Regular medicines

Year 20..... Date and month →

PRESCRIBER MUST ENTER administration times

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration:.....days Qty:.....

Date:

Pharmacist: Date:
Contact: Print your name:
Prescriber's signature: Date:

Refer overleaf for PRN medicines

Check if patient has another Medication Chart OFFICIAL: Sensitive//Medical in confidence Hospital Only Prescription

BINDING MARGIN - NO WRITING

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STANDARD ADULT GENERAL OBSERVATION CHART

FAMILY NAME
GIVEN NAME
D.O.B. ____/__/____
ADDRESS
MRN
☐ MALE ☐ FEMALE

PEREZ
SOFIA
2/12/1993
MRN 800965129
F
GENERAL MEDICAL WARD 1

☐ Altered Calling Criteria

LOCATION

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

		Date	9/8	9/8	9/8	9/8	9/8	9/8	9/8	Date
		Time	1000	1100	1345	1400	1445	1715	1800	Time
Patient / Family Concern Are you worried they are getting worse?		Yes								Yes
		No	✓	✓	✓	✓	✓	✓	✓	No
		Not asked								Not asked
AIRWAY/BREATHING	Respiratory Rate	35–5	x	x	x	x	x	x	x	35–5
	SpO_2%	100–85	x	x	x	x	x	x	x	100–85
	Oxygen	O_2Lpm								O_2Lpm
		Device / mode	RA	RA	RA	RA	RA	RA	RA	Device / mode
		Key: RA = Room Air, NP = Nasal Prongs, FM = Simple facemask, NRB = Non Re-breather, VM = Venturi Mask								
CIRCULATION	Blood Pressure (mmHg) SBP is trigger > <	230–50								230–50
	Heart Rate •	Rhythm								Rhythm
		160–40	x	x	x	x	x	x	x	160–40
Initials			IF	IF	IF	IF	IF	FG	FG	Initials

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STANDARD ADULT GENERAL OBSERVATION CHART

PEREZ
SOFIA
2/12/1993
MRN 800965129
F
GENERAL MEDICAL WARD 1

☐ Altered Calling Criteria

LOCATION

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

		Date	9/8	9/8	9/8	9/8	9/8	9/8	9/8	Date
		Time	1000	1100	1345	1400	1445	1715	1800	Time
DISABILITY	Neurological	A	A	A	A	A	A	A	A	A
		C								C
		V								V
		P								P
		U								U
		A= Alert, C= new confusion/change in behaviour, V= Rousable by voice (conduct GCS). P= Rousable only by pain (conduct GCS). U= Unresponsive								
PAIN		Assess pain level at rest and with movement. Enter R for at rest, M for movement								
		Severe (7-10)								Severe (7-10)
		Moderate (4-6)								Moderate (4-6)
		Mild (1-3)								Mild (1-3)
		Nil	RM	RM	RM	RM	RM	RM	RM	Nil
EXPOSURE	Temperature (°C) •	41–34	x	x	x	x	x	x	x	41–34
LACTATE		≥ 4 mmol/L								≥ 4 mmol/L
		2 to 3.9 mmol/L								2 to 3.9 mmol/L
		< 2 mmol/L								< 2 mmol/L
		BGL								BGL
		Bowels								Bowels
		Weight								Weight
		Initials	IF	IF	IF	IF	IF	FG	FG	Initials

URINALYSIS									
Date									Date
Time									Time
SG									SG
pH									pH
Leuk									Leuk
Blood									Blood
Nitrite									Nitrite
Ketones									Ketones
Bilirubin									Bilirubin
U/Bil									U/Bil
Protein									Protein
Glucose									Glucose

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STANDARD ADULT GENERAL OBSERVATION CHART

FAMILY NAME	MRN
GIVEN NAME	MALE
D.O.B. ____ / ____	
ADDRESS	
☐ Altered Calling Criteria	LOCATION
ALL OBSERVATIONS MUST BE GRAPHED	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PEREZ
SOFIA
2/12/1993 F
MRN 800965129
GENERAL MEDICAL WARD 1

OTHER CHARTS IN USE

☐ Neurological Observation ☐ Insulin Infusion ☐ Alcohol Withdrawal
☐ Fluid Balance ☐ Pain / Epidural / Patient Control Analgesia ☐ Resuscitation Plan
☐ Anticoagulant ☐ Neurovascular ☐ Other _____

PRESCRIBED FREQUENCY OF OBSERVATIONS

Observations must be performed routinely at least 6th hourly, unless advised below

DATE:	dd/MM/yy					
Time:	hh:mm					
Frequency Required	Twice daily					
Medical Officer Name (BLOCK letters)	A. CHANG					
Medical Officer Signature	A. Chang					
Attending Medical Officer Signature	J. Doe					

Alterations to calling criteria (ACC)
Acute ACC changes can be set for up to 12 hours. Chronic ACC changes apply for the episode of care
Any alterations MUST be signed by a Medical Officer and confirmed by the Attending Medical Officer
Document rationale for altering CALLING CRITERIA in the patient's health care record

DATE:	dd/MM/yy					
TIME:	hh:mm					
Next review due Date & Time	dd/MM/yy hh:mm					
ACUTE / CHRONIC	**ACUTE**					
Yellow Zone	XXX-XXX					
Red Zone	<= or >=XXX					
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Medical Officer Name (BLOCK letters)	A. CHANG					
Medical Officer Signature	A. Chang					
Attending Medical Officer Signature	J. Doe					

INTERVENTIONS / COMMENTS / ACTIONS

	Date	Time	
1.			
2.			
3.			
4.			

STANDARD ADULT GENERAL OBSERVATION CHART BSMOC150

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF YOUR PATIENT

Yellow Zone Response

IF YOUR PATIENT HAS ANY YELLOW ZONE OBSERVATIONS OR ADDITIONAL CRITERIA* YOU MUST

1. Initiate appropriate clinical care
2. Repeat and increase the frequency of observations, as indicated by your patient's condition
3. Consult promptly with the **NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the trend in observations suggest deterioration?
- Is there more than one Yellow Zone observation or additional criterion?
- Are you concerned about your patient?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess your patient and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned
2. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
3. Inform the Attending Medical Officer that a call was made as soon as it is practicable

***Additional YELLOW ZONE Criteria**

- Increasing oxygen requirement
- Poor peripheral circulation
- Excess or increasing blood loss
- Decrease in Level of Consciousness or new onset of confusion
- Low urine output persistent for 4 hours (< 100mLs over 4 hours or < 0.5mL/kg/hr via an IDC)
- Polyuria, in the absence of diuretics (urine output > 200mL/hr for 2 hours)
- Greater than expected fluid loss from a drain
- New, increasing or uncontrolled pain (including chest pain)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with no decrease in Level of Consciousness
- Ketonaemia > 1.5mmol/L or Ketonuria 2 + or more
- **Concern by patient or family member**
- **Concern by you or any staff member**

CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, A NEW ARRHYTHMIA, HYPOVOLAEMIA/HAEMORRHAGE, PULMONARY EMBOLUS/DVT. PNEUMONIA/ATELECTASIS, AN AMI, STROKE, OR AN OVERDOSE/OVER SEDATION

Red Zone Response

IF YOUR PATIENT HAS ANY RED ZONE OBSERVATIONS OR ADDITIONAL CRITERIA# YOU MUST CALL FOR A RAPID RESPONSE (as per local CERS) AND

1. Initiate appropriate clinical care
2. Inform the **NURSE IN CHARGE** that you have called for a **RAPID RESPONSE**
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
5. Inform the Attending Medical Officer that a call was made as soon as it is practicable

#Additional RED ZONE Criteria

- **Cardiac or respiratory arrest**
- **Airway obstruction or stridor**
- **Patient unresponsive**
- Deterioration not reversed within 1 hour of Clinical Review
- Increasing oxygen requirements to maintain oxygen saturation > 90%
- Arterial Blood Gas: PaO_2 < 60 or $PaCO_2$ > 60 or pH < 7.2 or BE < -5
- Venous Blood Gas: $PvCO_2$ > 65 or pH < 7.2
- Only responds to Pain (P) on the ACVPU scale
- Sudden decrease in Level of Consciousness (a drop of 2 or more points on the GCS)
- New or prolonged seizure activity
- Low urine output persistent for 8 hours (< 200mLs over 8 hours or < 0.5mL/kg/hr via an IDC)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with a decreased Level of Consciousness
- **Serious concern by any patient or family member**
- **Serious concern by you or any staff member**

BINDING MARGIN - NO WRITING