Provincial Blood Coordinating Program

SCIG Home Infusion Adverse Reaction Form

Newfoundland Labrador

After Administration of SCIG

You administered SCIG today and although rare, some people may experience a reaction. This may occur within hours, or after a few days. These reactions are usually mild; however, it is important to **watch** for and **report** any of the symptoms listed below.

SYMPTOMS TO WATCH FOR:

First 24 hours following administration:	Greater than 24 hours following administration:
▪ rash, hives, itching ▪ feeling sick or queasy, vomiting ▪ difficulty breathing ▪ increased coughing ▪ headache or lightheadedness ▪ sensitivity to bright light ▪ feeling very hot or feverish ▪ chills ▪ back pain ▪ red/brown urine	▪ headache ▪ sensitivity to bright light ▪ feeling very hot or feverish ▪ chills ▪ back pain ▪ red/brown urine ▪ yellow skin or yellow eyes ▪ feeling unusually or extremely tired

IF SYMPTOMS ARE SERIOUS

Contact your doctor or go to the nearest emergency department immediately.
Tell the staff that you have recently received a blood product.

If you have questions or concerns:

You can talk to your nurse case manager (from 8 am to 8 pm EST)
Or
NL Health line 24 hours a day, 7 days a week.
Dial 8-1-1 or 1-888-709-2929

Transfusion reactions must be reported.

If you have any of the symptoms shown above please fill out the form on the reverse of this page.

Return your Outpatient Transfusion Reaction Report Form:

- Mail form to <insert facility specific instructions>
- Fax form to <insert facility specific instructions>
- Return form in person to <insert facility specific instructions>

Form: NLSCIG-011
Effective Date: 2023-07-30

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Patient Details (can be addressographed)

Patient Name: **Facility name:**

Date of birth: **Date of administration:**

MCP number:

Physician's name:

Please complete the following:

Symptoms - **first 24 hours** post-administration	Symptoms - **greater than 24 hours** post- administration
☐ a rash ☐ hives ☐ itching ☐ unwell ☐ vomited ☐ difficulty breathing ☐ increased coughing ☐ headache ☐ sensitive to bright light ☐ very hot or feverish ☐ chills ☐ back pain ☐ red / brown urine	☐ a constant headache ☐ sensitive to bright light ☐ very hot or feverish ☐ chills ☐ back pain ☐ red / brown urine ☐ yellow skin or yellow eyes ☐ unusually or extremely tired

Did you take any medication for your symptoms? ☐ No ☐ Yes if yes, list the medications:

_____

Did you take your temperature? ☐ No ☐ Yes if yes, what was the reading? _____degrees

Date and time you took your temperature: Date: _____ Time: _____

Did you take your blood pressure? ☐ No ☐ Yes if yes, what was the reading? _____

Date and time you took your blood pressure: Date: _____ Time: _____

Did you contact your doctor? ☐ No ☐ Yes Doctor's name: _____

Best numbers to reach you: _____

Thank you for completing and returning this form.