Appendix 2: Transfusion Record

TRANSFUSION RECORD

Name :

Hospital Number :

Type of SCD:
Indication : **Start date :**
Aims :

DATE	PRE TX HB	PRE TX S%	POST TX HB	POST TX S%	VOLUME OF BLOOD	FERRITIN	Chelation	NOTES

Ophthalmology review : **Audiology review :**

Hepatitis B Sag: **Hepatitis C Ab : Anti-HBs titre:**