Clear Form

Transfusion Reaction and Adverse Event Form

LifeSouth Community Blood Centers

For Hospital Use

Case File Number:

Facility Information

Facility:		
Address:		
Attending Physician:	Phone:	Email:
Blood Bank Director/Manager:	Phone:	Email:
Form Completed by:	Phone:	Email:
Date Completed:	Time Blood Center Notified: : ☐ am ☐ pm/ ☐ET☐CT	

Patient Information

Patient Name:		
Sex :	DOB:	Patient ID:
Patient Diagnosis:		
Prior pregnancies? ☐ Yes ☐ No	If yes, how many?	☐ N/A

History of prior transfusion(s) ☐ Yes ☐ No

If yes, how many? _____ Product type? _____ Date(s): _____

Current Patient Status

☐ Recovered ☐ Not Recovered

☐ Suspected transfusion-related fatality; deceased date: ____/____/____ Reported to CBER: ____/____/____

List of Components Transfused

(if more than three products, attach information using same format)

DIN *(starts with W)*	Expiration Date	Product Code *(starts with E)*	Transfusion Date	Time of Infusion		Volume Transfused (mL)
				Start Time	*End Time*	
				:	:	
				:	:	
				:	:	
				:	:	
				:	:	
				:	:	
				:	:	

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Suspected Adverse Event

- ☐ Febrile Non-Hemolytic Reaction
- ☐ Transfusion-Related Acute Lung Injury (TRALI)
- ☐ Transfusion-Associated Circulatory Overload (TACO)
- ☐ Acute Hemolytic Reaction
- ☐ Delayed Hemolytic Reaction
- ☐ Allergic Reaction
- ☐ Anaphylactic Reaction
- ☐ Transfusion-Associated Bacterial Sepsis
- ☐ Transfusion Transmitted Infection

☐ Other(s) _____

Signs and Symptoms

☐ Anxiety	☐ Dark or red urine	☐ Hypertension	☐ Pain at infusion site
☐ Bradycardia	☐ DIC	☐ Hypotension	☐ Pruritus
☐ Back pain/Flank pain	☐ Dyspnea	☐ Hypoxemia	☐ Shock
☐ Chest Pain/tightness	☐ Edema	☐ Impending Doom	☐ Tachycardia
☐ Chills/Rigors	☐ Fever *(increase ≥ 1C, or >38C)*	☐ Loss of consciousness	☐ Uticaria
☐ Cough	☐ Hoarseness/Stridor	☐ Nausea/vomiting	☐ Wheezing
☐ Cyanosis		☐ Oliguria	

☐ X-ray changes post-transfusion (*describe*):

☐ Other (*Specify*): _____

☐ Asymptomatic

Culture results (if sent)	☐Pos ☐Neg ☐ N/A If positive, organism identified:

Vital Signs

	Pre-Transfusion	During Reaction	Post-Transfusion
Date/Time			
Temperature	°C/°F	°C/°F	°C/°F
Blood Pressure (Systolic)	mm Hg	mm Hg	mm Hg
Blood Pressure (Diastolic)	mm Hg	mm Hg	mm Hg
Pulse	bpm	bpm	bpm
Respiratory Rate	rpm	rpm	rpm
O2 Sat	%	%	%

The following sections are to be filled out as applicable for the type of suspected adverse event.

If a section is not applicable for the type of suspected adverse transfusion event, select the N/A box for that section.

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Hemolytic Transfusion Reaction Suspected	☐ N/A	
Error detected during clerical check	☐ Yes	☐ No
Hemolysis in plasma after transfusion	☐ Yes	☐ No
Incompatibility detected on ABO/Rh confirmation	☐ Yes	☐ No
Patient's DAT became positive after transfusion	☐ Yes	☐ No
Incompatibility detected on repeat compatibility testing	☐ Yes	☐ No
Patient's antibody screen changed after transfusion	☐ Yes	☐ No

TRALI* or TACO Suspected ☐ N/A

(Attach chest x-ray reports, if available)

TACO			TRALI		
☐ Y	☐ N	Elevated BNP or NT-ProBNP	☐ Y	☐ N	O2 sat ≤ 90% on Room air
☐ Y	☐ N	Evidence of left atrial hypertension	☐ Y	☐ N	PaO2/FiO2 ≤ 300 mm Hg
☐ Y	☐ N	Enlarged cardiac silhouette on chest imaging	☐ Y	☐ N	New unilateral infiltrates on x-ray
☐ Y	☐ N	Elevated pulmonary capillary wedge pressure	☐ Y	☐ N	No preexisting ALI or risk factors prior to transfusion; if no, please answer below
☐ Y	☐ N	Evidence of fluid overload			
☐ Y	☐ N	Improvements with diuretics			
☐ Y	☐ N	Onset within 6 hours of transfusion	☐ Y	☐ N	Onset within 6 hours of transfusion
☐ Y	☐ N	New Bilateral infiltrates on x-ray	☐ Y	☐ N	New Bilateral infiltrates on x-ray

If TRALI is suspected, please submit patient HLA typing when available. Corresponding donor HLA antibody testing will not occur until the results are available.

Risk Factors for Acute Lung Injury ☐ N/A

(before transfusion)

☐ Acute pancreatitis	☐ Drug overdose
☐ Acute Respiratory Distress Syndrome (ARDS)	☐ Multiple trauma
☐ Aspiration	☐ Near drowning
☐ Burn	☐ Pneumonia
☐ Cardiopulmonary bypass	☐ Pulmonary hemorrhage
☐ Chemotherapy	☐ Sepsis
☐ DIC	☐ Shock
☐ Diffuse alveolar damage	☐ Toxic inhalation

☐ Other (Specify): _____

Transfusion Transmitted Infection Suspected ☐ N/A

(attach screening and confirmatory diagnostic test results with dates)

☐ Hepatitis C Virus	☐ Babesiosis
☐ Hepatitis B Virus	☐ Malaria
☐ Human Immunodeficiency Virus	☐ Chagas disease (*Trypanosoma cruzi*)
☐ West Nile Virus	☐ Other (specify):

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Transfusion-Associated Bacterial Sepsis Suspected *(if available, please return the product to LifeSouth for further investigation)*	☐ **N/A**
Abnormal product appearance? ☐ Yes ☐ No If yes, describe: _____	Patient blood cultures pre-transfusion? ☐ Yes ☐ No If yes, describe: _____
Gram stain performed on unit? ☐ Yes ☐ No If yes, describe: _____	Patient blood cultures post-transfusion? ☐ Yes ☐ No If yes, describe: _____
Culture performed on unit? ☐ Yes ☐ No If yes, describe: _____	Other testing performed? ☐ Yes ☐ No If yes, describe: _____

Additional Comments *(attach supporting documentation, if necessary)*	
Completed by:	Date:

For Internal Use Only
Date/Time Medical Director Notified: _____ /_____/_____ at _____ : _____ ☐am ☐pm / ☐ET ☐CT
Hold placed on each DIN by (initials): on _____ /_____/_____

FAX WITH TRANSFUSION REACTION WORKUP AND MEDICATION LIST TO (888) 286-0179 • CONFIRM FAX RECEIVED AT (352) 224-1770
AFTER NORMAL BUSINESS HOURS (9AM TO 5PM ET, M-F), FAX TO (352) 334-1029 • CONFIRM FAX RECEIVED AT (352) 334-1028