

7.1 Associated Materials

**REPORT OF POST TRANSFUSION ADVERSE EVENT
Hospital Information**

Date: _____

Reporting Facility: _____

Blood Bank Director: _____ Contact Person: _____

Address: _____

Contact Telephone #: (____) _____ Fax #: (____) _____

Classification of Adverse Event			
Immunological		Infectious Disease	
<input type="checkbox"/> Hemolytic reaction	<input type="checkbox"/> Anaphylactic reaction	<input type="checkbox"/> HBV	<input type="checkbox"/> HCV
<input type="checkbox"/> Transfusion related acute lung injury (TRALI)	<input type="checkbox"/> Other	<input type="checkbox"/> HIV 1/2	<input type="checkbox"/> HTLV-I/II
		<input type="checkbox"/> Bacterial Contamination	<input type="checkbox"/> Babesiosis
		<input type="checkbox"/> Other	

Patient Information			
Medical Rec # /ID:		Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Previous Transfusions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, <input type="checkbox"/> < 1 month ago <input type="checkbox"/> > 1 month ago		Pregnancy History:	
Previous Transfusion Reactions: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of reaction:			

Current Event
Primary diagnosis:
Indications for transfusion:
Clinical condition of patient at time of transfusion:
Current status of patient:

IMPLICATED NYBC BLOOD PRODUCTS (Attach additional forms if necessary)	# of <u>non</u> NYBC units _____
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Date & Time of Tx.	NYBC #	Product Type

Fill out appropriate post transfusion event section

Hemolysis

Was the patient in surgery when hemolysis was noted? _____

- 1. On or after using a bypass pump? _____
- 2. Cardiac valve replacement? _____
- 3. Was a Cell Saver used? _____ Was the blood washed? _____ Unwashed? _____

Was the blood warmed in some way? _____ Method: _____

Was the blood stored in a non-temperature controlled refrigerator? _____

Was the blood transfused under pressure? _____

Was the blood given with other fluids or medications? _____ Specify: _____

How many of the units were frozen deglycerolized red cells? _____

Does the patient have extensive muscle injuries or crush injuries? _____ Specify: _____

Is there a history of diseases associated with autoimmune hemolytic anemia? _____

Is the patient infected with an organism causing hemolysis? (e.g., clostridial infection, malaria, babesiosis)

Labs (LDH, Bilirubin, total and direct Coombs, other) _____

Bacterial Contamination

Elapsed time between the issuance of unit(s) by the blood bank and the actual transfusion? _____

Was the transfusion interrupted? _____

Were the units returned to the blood bank? _____

Did the physical bag and/or contents present any abnormality on visual inspection? _____

Color of supernatant of segment tubing? _____

What time period elapsed between the end of the transfusion and culture of the product? _____

Labs: Culture of product

Culture of patient sample

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Infectious Diseases

Has the patient been assessed for risks of exposure (e.g., IV drug use, tattoos, acupuncture, ear piercing, venereal disease, sexual contact with infected partner, etc.)? _____

Could the event be related to causes other than the transfusion. (Dialysis, receipt of clotting factors in the past, occupational exposure to blood or body fluids (needle stick, spill, bite, etc) _____

Labs (serologic, LFTs, smears):

Pre Transfusion _____

Post Transfusion _____

TRALI

In order to evaluate reports of TRALI and address donor issues, it is important to only report a case when TRALI is a realistic option in the differential diagnosis and that complete clinical and laboratory information is provided. TRALI is a clinical diagnosis and is based on the patient's clinical, radiological, and laboratory information. Presence of antibodies in donor sera cannot be used to support the diagnosis of TRALI if a match cannot be established between the specificity(ies) of donor antibodies and of corresponding antigen(s) on leukocytes of the recipient. We therefore request submission of donor blood samples (residual bag contents or segment) and recipient buccal cell and peripheral blood samples to genotype and cross-match with donor serum.

Underlying Medical Condition: _____

Medications given within 2 hours of transfusion reaction _____

Pre-existing Respiratory Insufficiency: No ___ Yes (Specify) _____

History of relevant CVD _____

Dyspnea: Onset After Infusion of Suspected Unit: < 2hr __, 2-6 hr __, 6-8 hr __, >8hr __

Blood Gases: SO₂ _____ or PaO₂/FiO₂ _____

WBC / ANC: Before Onset _____ Date and time _____
After Onset _____ Date and time _____

Chest X-Ray: Before Onset _____, After _____

SIGNS OF CHF: Neck Vein Distension __, Pos HJ Reflex __, S3 Gallop __ CVP ____, PAWP ____

B Natriuretic Peptide Level _____

Response to Diuresis: _____

Other therapy given: _____

Time to Resolution: < 6 hours ____, 6-12 hours ____, 12-24 hours ____, > 24 hours ____

Labs

Patient HLA type, HLA antibodies _____

Product HLA and/or granulocyte antibodies _____

