The Blood Center, New Orleans, LA **Post Transfusion Adverse Event Report Form**

Please Print the information required below. TBC Assigned number: _____

Reporting Hospital/Telephone Number: _____Name: _____

Email Address: _____ Report Date: _____

Reported to TBC (Name of person receiving the report): _____

This form must be returned to The Blood Center upon initial notification of the Post Transfusion Adverse Event.

Section A: Patient Information

Patient ID #: _____ Gender: ☐Male ☐Female Age: _____

Transfusion Date(s): _____ Blood Component(s) & Number Transfused:

_____

_____

Blood Products from other facilities transfused in addition to TBC Blood Components: *Yes☐ or ☐No
*If yes, list the product codes, number of transfusions per product code and the dates of transfusion below.

_____

_____

_____

Date/Time Event occurred: ___/___/___; ___: ___ ☐am ☐pm

Underlying disease(s): _____

_____

Patient status prior to transfusion/patient course:

_____

_____

_____

Patient Transfusion and Pregnancy History

Prior transfusion: *Y☐ N☐ *Dates/blood component(s) _____

Any significant observations made of patient after prior transfusion(s):

_____

_____

_____

Prior pregnancies: *Y ☐ N☐N/A ☐ *If yes, how many: _____2nd ID of patient and units correct: Y☐ N☐

Pre-transfusion VS: BP _____ Pulse_____Temp_____RR_____SaO_2_____%

VS @ time of reaction: BP _____ Pulse_____Temp_____RR_____SaO_2_____%

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Signs and symptoms if present (check those that apply)

Anxiety	☐	Fever (>1° C or 2° F △)	☐	Hypotension or significant decrease in BP	☐	Shock	☐
Back pain	☐	Flushing	☐	Pain at IV site	☐	Tachycardia	☐
Chest pain	☐	Headache	☐	Nausea/vomiting	☐	Rash	☐
Chills/Rigors	☐	Hemoglobinuria/Dark Urine	☐	Bleeding from puncture sites	☐	Urticaria	☐
Cyanosis	☐	Red plasma	☐	Oliguria/anuria	☐	Wheezing	☐
Dyspnea	☐	Hypertension	☐	Diffuse Hemorrhage	☐	Other (specify)	☐
O_2 Sat	☐	X-Ray indicated	☐				

List components supplied by TBC suspected in event

Unit No.	Component	Blood Type	Unit No.	Component	Blood Type

Recipient laboratory results (provide those that are relevant to the event)

Pre-transfusion		Post-transfusion	
Blood type		Blood type	
Antigen phenotype		Antigen phenotype	
Antibody screen		Antibody screen	
Hemoglobin		Hemoglobin	
WBC		WBC	
Platelets		Platelets	
Bilirubin (direct/indirect)		Bilirubin (direct/indirect)	
LDH		LDH	
Reticulocytes		Reticulocytes	
BUN/Creatinine		BUN/Creatinine	
Urine Hemoglobin		Urine Hemoglobin	
Other (e.g. DAT)		Other (e.g. DAT)	

Section B: Suspected adverse event (check those that apply)

Acute hemolytic reaction	☐	Acute lung injury (TRALI) **(go to section C)**	☐
Delayed hemolytic reaction	☐	Circulatory overload (TACO) **(go to section C)**	☐
Febrile nonhemolytic reaction	☐	Graft-vs.-host disease (TAGVHD)	☐
Allergic or anaphylactic reaction	☐	Post-transfusion purpura	☐
Transfusion-associated bacterial sepsis	☐		☐

Transfusion-associated infection suspected (check the agent)

Hepatitis C Virus (HCV)	☐	Babesiosis	☐
Hepatitis B Virus (HBV)	☐	Malaria	☐
Human Immunodeficiency Virus (HIV 1/2)	☐	Chagas Disease (Trypanosoma cruzi)	☐
West Nile Virus (WNV)	☐	Syphilis	☐
Human T-Lymphotropic Retrovirus (HTLV I/II)	☐	Other (specify agent) _____	☐
Cytomegalovirus (CMV)	☐		

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For suspected transfusion transmitted infection specify both screening and confirmatory diagnostic test results supporting that suspicion

Pre-transfusion	Post-transfusion

Section C: For TRALI and TACO reports (check Y or N)

Acute onset	Y ☐	N ☐	Diagnosis of congestive heart failure	Y ☐	N ☐
Onset within 6 h of transfusion	Y ☐	N ☐	Cardiomegaly on chest x-ray	Y ☐	N ☐
PaO_2/FiO_2 <300	Y ☐	N ☐	Elevated B-natriuretic peptide	Y ☐	N ☐
O_2 sat <90%	Y ☐	N ☐	Elevated pulmonary capillary wedge pressure	Y ☐	N ☐
Required new mech. ventilator	Y ☐	N ☐	Low ejection fraction at cath. or on echo	Y ☐	N ☐

Risk factors for acute lung injury present in the patient before transfusion (check Y or N)

Aspiration	Y ☐	N ☐	Shock	Y ☐	N ☐
Preexisting pneumonia	Y ☐	N ☐	Multiple trauma	Y ☐	N ☐
Toxic inhalation	Y ☐	N ☐	Burn injury	Y ☐	N ☐
Lung contusion	Y ☐	N ☐	Pancreatitis	Y ☐	N ☐
Near drowning	Y ☐	N ☐	Cardiopulmonary bypass	Y ☐	N ☐
Sever sepsis	Y ☐	N ☐	Drug overdose	Y ☐	N ☐

Send chest x-ray reports (patient identifiers obscured) for suspect TRALI & TACO.

Please return the completed form with any supporting documentation to the address below.

Director of Quality Assurance and Compliance
1310 JW Davis Drive
Hammond, La 70403

Received by: _____ **Date:** ____/____/____

MD Review: _____ **Date:** ____/____/____