Use this form to report possible transfusion-associated adverse events such as TRALI, bacterial contamination, and transfusion-associated GVHD. Transfusion-transmitted infections including viral, parasitic, and prion infections should not be reported with this form.

Reporting Hospital:	Date:
Individual Reporting:	Contact Phone #:
Blood Bank Medical Director:	Contact Phone #:
Recipient's Physician:	Contact Phone #:
Alternate Physician:	Contact Phone #:

Recipient Name:	DOB:	Hospital ID#:
Underlying illness or surgery:		
Is this a transfusion related fatality? *(If Yes, you must notify FDA within 24 hours)*…… ☐ **Yes** ☐ **No**		
Date/Time of Adverse Event:		
Suspected transfusion associated adverse event:		

List all involved units of blood, blood component, or blood derivative administered to the patient (include products from all sources). For TRALI, only include products transfused within 6 hours prior to beginning of symptoms. For TA-GVHD, include all products transfused within 3 weeks of beginning of symptoms and denote whether or not each product was irradiated.

	Source	Type of Product	Whole Blood Number/Lot #	Transfusion Start Time/Date	Transfusion Stop Time/Date
1.					
2.					
3.					
4.					
5.					
6.					

Attach additional forms if more than 6 products transfused.

Has this case been reviewed by Hospital Transfusion Committee? …… ☐ **Yes** ☐ **No**

If Yes, Transfusion Committee conclusions:

Please describe the adverse event:

Please complete for possible TRALI

Are the following present?					
Acute onset of respiratory distress?	☐ **Yes**	☐ **No**			
Hypoxemia as defined as one of the following?					
- PaO2/FIO2<300 mm Hg	☐ **Yes**	☐ **No**	If Yes, value: _____		
- Oxygen saturation <90% on room air ..	☐ **Yes**	☐ **No**	If Yes, value: _____		
- Other clinical evidence (please explain):					
Bilateral lung infiltration in the chest radiograph?	☐ **Yes**	☐ **No**			
- Please attach radiology report if available					
Possible circulatory overload?	☐ **Yes**	☐ **No**			
- Central venous pressure (time): _____					
- History of heart failure/medications?:					
Are any of the following present prior to transfusion?					
- Sepsis or Septic Shock …….	☐ **Yes**	☐ **No**	Drug overdose	☐ **Yes**	☐ **No**
- Aspiration …….....	☐ **Yes**	☐ **No**	Burn injury	☐ **Yes**	☐ **No**
- Lung contusion……	☐ **Yes**	☐ **No**	Cardiopulmonary bypass	☐ **Yes**	☐ **No**
- Pneumonia ……	☐ **Yes**	☐ **No**	Inhalation injury.....	☐ **Yes**	☐ **No**
- Multiple trauma ……	☐ **Yes**	☐ **No**	Acute pancreatitis	☐ **Yes**	☐ **No**
- Any other acute lung injury or risk factor?					
Recipient HLA Class I and II typing has been ordered	☐ **Yes**	☐ **No**			
Recipient Human Neutrophil Antigen (HNA) has been ordered	☐ **Yes**	☐ **No**			
- Please attach HLA and HNA reports if available					

Note: Recipient HLA Class I and II typing and HNA typing must be known to implicate a donor in TRALI. SDBB will not routinely test donors for antibodies to HLA or HNA if the transfusion service has not ordered recipient typing. Please contact us with questions concerning testing. SDBB can arrange to send out donor testing in coordination with the transfusion service. The transfusion service will be billed for the costs of recipient testing.

Please complete for suspected BACTERIAL CONTAMINATION

Are the following present?
What are the findings in the recipient? - Temp pretransfusion _____ Temp posttransfusion _____ - Temp max 24 hrs prior to transfusion _____
What are the culture results? - Patient culture results (site, organism) _____ - Blood product culture results (time of transfusion, culture, findings)
Was blood product hemolyzed? ..... ☐ **Yes** ☐ **No**
Does patient have other infections prior to transfusion? ☐ Yes ☐ No …… If yes, please describe: Additional information:

Please complete for Transfusion-Associated Graft vs. Host Disease (GVHD)

Possible TA-GVHD
Is the patient immunocompromised ..... ☐ **Yes** ☐ **No** - If yes, please explain:
Did the patient receive non-irradiated cellular blood products within 3 weeks of symptoms ..... ☐ **Yes** ☐ **No** Were any units directed donations from family members ..... ☐ **Yes** ☐ **No** Did the recipient receive HLA matched platelets within 3 weeks of symptoms ..... ☐ **Yes** ☐ **No** Has the patient had a bone marrow or organ transplant ..... ☐ **Yes** ☐ **No**

Please complete for Posttransfusion Purpura (PTP)

Possible PTP
PTP is usually characterized by a dramatic thrombocytopenia 5-10 days following a blood transfusion in a patient with a history of sensitization to platelet specific antigens by pregnancy or transfusion.
Pretransfusion plt ct/date: _____ Lowest Posttransfusion plt ct/date: _____ History of pregnancy ..... ☐ **Yes** ☐ **No** Previous history of Neonatal Alloimmune Thrombocytopenia in children ..... ☐ **Yes** ☐ **No** History of previous transfusion ..... ☐ **Yes** ☐ **No** Did the recipient receive HLA matched platelets within 3 weeks of symptoms ..... ☐ **Yes** ☐ **No** Has the patient had a bone marrow or organ transplant ..... ☐ **Yes** ☐ **No** Please explain:
Please attach relevant laboratory values including platelet specific antigens or antibodies.

Mail or Fax to: Medical Director, San Diego Blood Bank
3636 Gateway Center Ave, Suite 100 San Diego, CA 92102
Fax # 619-220-8416