To be completed by the Transfusion Service

RECIPIENT INFORMATION

Hospital ______________________________ Date/Time of Reaction ____________________

Recipient Name: ____MRN: ____________

Recipient Primary Diagnosis (es) ____

Requesting Clinician (phone/pager):____

Please provide a summary of the transfusion reaction. Please include units transfused and details related to timing of symptoms or findings if possible. May affix summary on separate page if more space is required. Please include Hospital Medical Director summary if completed. If report is related to new infectious disease found in a transfusion recipient, please include specific list of tests that were performed and positive including dates of tests AND prior negative results if available.

COMPLETE FOR RESPIRATORY TRANSFUSION REACTION

1. Please complete the following questions:
   - A. Onset of symptoms < 6 hours after initiation of the transfusion ❑ Yes ❑ No
   - B. Evidence of hypoxemia (choose all that may apply): ❑ Yes ❑ No
     - ❑ PaO_2 / FIO_2 ≤ 300 mmHg (or PaO_2 _____ FiO_2 at time of reaction)
     - ❑ O_2 Sat 90% on room air
     - ❑ Other findings
   - C. Evidence of volume overload (choose all that may apply, if answer Yes) ❑ Yes ❑ No
     - ❑ Echocardiography demonstrating left ventricular ejection fraction ≤ 40% or history of congestive heart failure
     - ❑ Elevated BNP (> 100 pg/ml)
     - ❑ Elevated pulmonary wedge pressure (> 10 mmHg)
     - ❑ Elevated pulmonary arterial diastolic pressure (≥ 18 mmHg)
2. Chest X-Ray results: ❑ Yes (please attach pre- and post-transfusion reports) ❑ No

COMPLETE FOR BACTERIAL CONTAMINATION CONCERN

Please provide the following:

	PreTransfusion	Post-Transfusion
Pt temperature		
Does patient have current infection or recurrent fever? Are component culture status or results? Please attach Hospital investigation summary if available.		

Additional findings or laboratory results or other comments:

UNITS INVOLVED IN TRANSFUSION REACTION

Component Code/Type	Date/Time of Tx	Unit Number	Comments