

INVESTIGATION OF SUSPECTED TRANSFUSION REACTION

Case #: _____

Hospital to complete the following:

Patient Name: _____	Hospital: _____
Patient Diagnosis: _____	
Current Medical Problems:	<input type="checkbox"/> CHF <input type="checkbox"/> Acute MI <input type="checkbox"/> Bacterial Infection / Sepsis <input type="checkbox"/> Acute Respiratory Distress Syndrome <input type="checkbox"/> Other: _____
Transfusion Date/Time: _____	Reaction Date/Time: _____
Type of Reaction:	<input type="checkbox"/> Hemolytic <input type="checkbox"/> Anaphylactic <input type="checkbox"/> Bacterial Contamination <input type="checkbox"/> TRALI <input type="checkbox"/> Volume Overload <input type="checkbox"/> Other: _____

Vital Signs	Pre-Transfusion	Post-Reaction
Temperature		
Blood Pressure		
Pulse		
Respiration Rate		

Chest X-Ray Findings: _____		
Fluid Balance <i>[Previous 24 hours]</i>	Volume In: _____ Volume Out: _____	Is Input & Output Record attached? <input type="checkbox"/> Yes <input type="checkbox"/> No

1. List all **Suspect Products Transfused** in the columns provided on page 2 of this form. **Note:** Return blood bag(s) of all suspected products transfused to CBC, if available.
2. Attach a copy of the **Transfusion Service Reaction Workup**. Workup not performed at hospital
3. Attach a copy of the **Patient's Transfusion Record**, if available.
4. **Pre-Transfusion** and **Post-Transfusion** EDTA and Red Top Samples from the patient must be shipped to CBC for investigation workup.
5. If **TRALI** is suspected, please complete the **HLA Laboratory Requisition Form** (HLA-2001).

For CBC Use Only	Date/Time CBC Notified: _____	By (Hospital Employee): _____
	CBC Employee Notified: _____	
	Type of Notification:	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Other: _____
	Department Director: _____	Notified Date/Time: _____
	Medical Director: _____	Notified Date/Time: _____

Investigation of Suspected Transfusion Reaction (continued):

Case #: _____

To be completed by Hospital			To be completed by CBC			
DIN	Implicated PCode	Product Bag Available?	Associated Products Not Transfused or Not Recovered		Final Product Disposition	
					Medical Director Approval to Release	Comments
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Associated Products were: Returned to Inventory Discarded By/Date: _____

CBC Medical Director Conclusion: _____

Comments: _____

Medical Director Signature/Date: _____

Case Findings Reported to Hospital By/Date: _____