Reported by Hospital Tech: Date:	**Sample(s) Requested for TRALI Investigation by MBS:** **1) 5 ml serum from patient** **2) 1-5 ml serum from the donor blood product unit if available from segments, sample from bag or bag**
Reporting Health Care Facility/Hospital Address:	FOR MISSISSIPPI BLOOD SERVICES USE ONLY: Report received by MBS Tech: Date: MBS Case ID Number:

Possible TRALI Transfusion Reaction Case Report

Section I: Clinical Information

Patient (Recipient) Name:		
Patient (Recipient) ID #:	Age or DOB:	Sex: □Female □Male
Primary Diagnosis(es):		
Transfusion Service Medical Director:		Phone:
Attending Physician		Phone
Resident Physician		Phone
Contact for Additional Clinical Info:		Phone:

Date/time evidence of reaction began: _____

Fatality? □**No** □**Yes** ► Date and time of death _____

If died, will autopsy be performed?

□**No** □**Yes** Transfusion fatalities must be investigated urgently and are reportable to the FDA.

Which of the following developed during or within 6 hours following transfusion? Check all that apply:

- □ Fever (≥39 °C or ≥2 °C rise)
- □ Rigors
- □ Tachycardia (≥120/min or ≥40/min rise)
- □ Rapid breathing (≥28/min)
- □ Rise in systolic BP of ≥30 mmHg
- □ Drop in systolic BP of ≥30 mmHg
- □ Hypoxemia (PaO_2 <60, O_2 sat <90%)
- □ Hematuria or hemoglobinuria
- □ Bronchospasm/wheezing
- □ Jugular venous distension
- □ Nausea or vomiting
- □ Pulmonary edema
- □ Abdominal pain
- □ Lumbar pain
- □ Chest pain
- □ Cardiac arrhythmia
- □ Urticaria/hives
- □ Itching
- □ Laryngeal edema

Describe reaction in more detail _____

_____

_____

Possible Transfusion Reaction Report

FOR MISSISSIPPI BLOOD SERVICES USE
Case ID Number:

Was a post-transfusion chest X-ray done? ☐**No** ☐**Yes,** result _____

Summary of patient's status, treatment, and response at the time of this report: _____

What other events could explain the findings in this patient, other than transfusion? (i.e., sepsis, drug reaction, volume overload, heart failure, hemorrhagic shock, allergic or anaphylactic reaction) _____

Section II: Hospital Transfusion Service Record

Did the patient receive any components not provided through / by Mississippi Blood Services? ☐**No** ☐**Yes**

Please list all suspect components provided by Mississippi Blood Services

Hospital Transfusion Service Use						
Unit Number *List pooled components individually*	**Component Name** *(e.g.FFP,RBC, etc.)*	**Date of Transfusion**	**Start Time**	**End Time**	**Volume Transfused (¼, ½, all) or amt. (cc)**	**Sample from Product or Product Bag Returned to MBS? (Record N/A if not available)**

****Attach additional sheets, as required, to report all potentially involved transfusions****

Possible Transfusion Reaction Report

FOR MISSISSIPPI BLOOD SERVICES USE
Case ID Number:

Summarize patient's previous transfusion history. (Include nature of prior reactions and types of components transfused)

_____
_____
_____

Were any of the involved components modified by the transfusion service or the *hospital* transfusion care area? (Pooled, aliquot, warmed, irradiated, washed, leukocyte-reduced by filtration, other) _____

_____
_____

Routine Transfusion Reaction Work-up *Complete or attach sheets.*

1) Clerical error(s)? (i.e., correct unit, correct recipient) □ **Correct** □ **Incorrect**

2) Appearance of returned blood bag and contents: □ **Normal** □ **Abnormal** □ **Not returned**
Describe any problems: _____
_____

3) Appearance of returned solutions, tubing and filters: □ **Normal** □ **Abnormal** □ **Not returned**
Describe any problems: _____
_____

Please return any residual component(s) to the blood center for further investigation

Confirmation of compatibility:

	Pre-Transfusion	**Post-Transfusion**
ABO/Rh type		
Antibody Screen		
Crossmatch		
Direct Antiglobulin Test		
Other		

Special Transfusion Reaction Workup

Were other special blood components studies performed? (i.e., measurement of IgA, red cell antibody titers, red cell phenotyping, measurement of free hemoglobin or supernatant potassium)

List all applicable studies: Or attach sheets

_____
_____
_____

Possible Transfusion Reaction Case Report

FOR MISSISSIPPI BLOOD SERVICES USE
Case ID Number:

Complete the following for potential septic reactions *(possible bacterial contamination of the blood component):*

Residual component/blood bag Sample Source: ☐ **Bag** ☐ **Segment** ☐ **Infusion set/tubing**

Sample Condition: ☐ **Aseptic** ☐ **Clean** ☐ **Retrieved from trash**

Gram stain: ☐ **Negative** ☐ **Not done** ☐ **Positive:** _____

Culture(s): ☐ **Negative** ☐ **Not done** ☐ **Positive:** _____

Patient's blood cultures

Pretransfusion: ☐ Not done ☐ Date Performed _____
☐ Negative ☐ Positive for: _____

Post-transfusion ☐ Not done ☐ Date Performed _____
☐ Negative ☐ Positive for: _____

Section III: Hospital Transfusion Service Medical Director's Summary

SUSPECTED CAUSES *(check appropriate box):*

☐ Septic reaction
☐ Transfusion-related acute lung injury (TRALI)
☐ Anaphylaxis
☐ Other _____
☐ Hemolytic reaction
☐ Electrolyte abnormality (K^{+}, Ca^{++})
☐ Volume overload

From a physician's perspective, what is the likelihood that a transfusion caused this event?
☐ Certain ☐ Likely ☐ Possible ☐ Can't exclude ☐ Unlikely

Transfusion Service Medical Director Name _____

Signature _____Date_____

Thank you. Please fax this form to Mississippi Blood Services at:

Contact Name: MBS Laboratory Management Staff	Fax: **601 368 – 9561**
Address:	Mississippi Blood Services, 1995 Lakeland Drive, Jackson, MS 39216-5095
Phone:	601 368-2618
Email contact: pjett@msblood.com; ddriver@msblood.com	