REPORT OF SUSPECTED TRANSFUSION ASSOCIATED INFECTION

Contact: Suzanne Hilton (817) 412-5604, Toll-free 1-(888) 480-8200,
Email: DN@carterbloodcare.org, Fax: (817) 412-5609

Case # _____ **Date:** _____

Patient Information

ID/MR #:_____ DOB: _____

Suspected Transfusion Associated Infection: (Mark appropriate box) ☐ HIV ☐ HCV ☐ HBV ☐ HTLV ☐ WNV ☐ Other _____

Diagnosis at time of transfusion: _____ Reason for transfusion: _____

Does patient have risk for infection in question other than transfusion? ☐ Yes ☐ No (if "yes," explain): _____

Patient symptoms suggesting infection: _____ Date of onset: _____

Any drug exposure that could produce similar symptoms of infection? ☐ Yes ☐ No (if "yes," explain): _____

Did patient receive IV gamma globulin? ☐ Yes ☐ No

Are pre-transfusion laboratory tests for the suspected infection provided? ☐ Yes ☐ No (Please attach copies)

Date post transfusion testing performed: _____ *Attach copies of ALL Laboratory Reports, including confirmation tests*

Transfusion Information

Transfusing facility name: _____ City: _____ State: _____

List all blood components administered prior to onset of suspected transfusion transmitted infection

Component Code:

No.1 - Whole Blood 2 - Red Blood Cells 3 - Platelet Pheresis 4 - Platelet pool 5 - Plasma 6 - Cryoprecipitate 7 - Granulocyte 8 - Stem Cell

Component Code No.	DIN (Donation Identification Number)	Date Used	Component Code No.	DIN	Date Used	Component Code No.	DIN	Date Used

Reporting Institution Name: _____

Address: _____
Street City State Zip Code

Reported by: _____ Title: _____ Phone: _____
Printed Name

_____
Signature

Carter BloodCare Use

Received by: _____ Employee #: _____ Date: _____

Medical Director Case Disposition: ☐ Accept ☐ Decline as TTI ☐ Incomplete

Etiologic Category: ☐ HIV ☐ HCV ☐ HBV ☐ HTLV ☐ WNV ☐ Other: _____

Medical Director Signature: _____ Date: _____

REPORT OF TRANSFUSION-RELATED ACUTE LUNG INJURY INVESTIGATION

Contact: Suzanne Hilton (817) 412-5604, toll-free: 1-(888) 480-8200, email: DN@carterbloodcare.org, fax: (817) 412-5609

To Hospital Staff:

If you suspect your patient has had a TRALI reaction, please complete this form and fax to Carter BloodCare. Notify the Transfusion Service/Blood Bank ASAP. You may also wish to have your patient tested for leukocyte antigens/antibodies (see instructions on page 2).

Case #

Date of Report: _____ Hospital: _____

Hospital Address: _____

Reported By: _____ Phone Number: _____

Attending MD: _____ Phone/Pager: _____

Email Address (if you would like your report sent to you by email): _____

Carter BloodCare Staff Only

Received By: _____ **Date:** _____

MD Signature: _____

Date: _____ **Accept** ☐ **Decline** ☐

Transfusion Information

Please list units transfused at time of, or within 6 hours of the onset of symptoms:

Unit Number	Type of Product	Date Transfused	Transfusion Start Time	Transfusion End Time

Please submit completed form to:
Carter BloodCare, Donor Notification (FAX) (817) 412-5609

Submitted By: _____
Date: _____
Signature: _____
Phone: _____

REPORT OF TRANSFUSION-RELATED ACUTE LUNG INJURY INVESTIGATION

Contact: Suzanne Hilton (817) 412-5604, toll-free: 1-(888) 480-8200, email: DN@carterbloodcare.org, fax: (817) 412-5609

Recipient Information

Case #

Date and time of suspected transfusion reaction: _____

Location of transfusion (e.g. ICU): _____

Recipient ID/MRN: _____ DOB: _____ ☐ Male ☐ Female

Patient diagnosis: _____

Reason for transfusion: _____

Vital Signs

	Pre Transfusion	During Transfusion	Post Transfusion
Temperature			
Blood Pressure			
Heart Rate			
Respiratory Rate			
% O_2 Saturation			

Clinical Manifestations

	Yes/No/Unknown	Value	Comments
Fever > 99.6			
Chills/Rigor			
Dyspnea			
Tachypnea			
Wheezing			
O_2 Sat < 90% RA			
Hypotension < 90 syst.			
Tachycardia > 110			
N/V			
Respiratory Failure			

Labs/Radiographic Studies

	Yes/No/Unknown	Value	Comments
Chest X-Ray (Alveolar Infiltrates)			
Arterial Blood Gas (PaO_2/Fi O_2)			
Low WBC Post – Tx			
BNP			

Has patient ever been tested for leukocyte Abs/Ags? ☐ No ☐ Yes Results: _____

For information about patient testing, contact the ARC Neutrophil Laboratory Services at (651) 291-6797 or (877) 447-6489.

Clinical Course/Event Summary:

Please attach applicable lab reports, notes, radiographic reports, etc.

Carter BloodCare

SUSPECTED TRALI INVESTIGATION SUMMARY

Date: _____

Investigation status: **Initial** ☐ **Pending** ☐ **Final/Closure** ☐

CBC Case #: _____ Hospital/Facility: _____

Date of Transfusion: _____ Date Reported: _____

Patient ID, if provided: _____ Reported By: _____

Patient Information Symptom

Dyspnea	Tachypnea	Cough	Fever	Hypo tension	Rash	Nausea	Hypoxemia	Rales	Wheeze	Chills	Hyper tension	Tachy cardia	Resp Failure

X-ray

Donor Information

DIN #	Gender of Donor	Component Type	Previous Transfusions? Y/N **	History of Pregnancy Y/N	Tested? Y/N	Granulocyte Antibodies	HLA Class I	HLA Class II

****The donor is asked if they have a history of transfusion, organ tissue or cellular transplant.**

Additional Donor Information

DIN #	

Comments:

If you have any questions, please contact:
Suzanne Hilton MT, (ASCP)
Donor Notification Manager
Phone: (817) 412-5604 Fax: (817) 412-5609 Email: DN@carterbloodcare.org

DNF106.30D
Version: 03
Effective Date: 12/14/2021

REFERENCE AND TRANSFUSION SERVICES
TRANSFUSION REACTION INVESTIGATION
PRELIMINARY REPORT

Carter BloodCare

Patient Name:		Sample Collection Date & Source:	
ID Number:		Date Request Received:	
Requesting Facility:		Diagnosis:	
Ordering Physician:		Patient Date of Birth & Gender:	

UNIT INFORMATION

Unit Number: _____ Date/Time of Transfusion Reaction: _____

Component Involved: _____ Amount Transfused: _____ ml

REACTION DETAILS

	Chills present		Nausea/Vomiting	**Other listed below**
	Fever		Urticaria / Hives / Rash	
	Dyspnea		Hematuria	
	Shock		Back or Chest Pain	
	Jaundice			

INVESTIGATION FINDINGS

	Clerical checks were performed and found acceptable		Discrepancy noted in Clerical/Visual paper work check
	Visual inspection of the pre- and post-sample was normal		Hemolysis present in post transfusion sample
	Pre and Post transfusion sample testing resulted in no discrepancies		Discrepancy noted in sample testing
	There is no evidence of red cell incompatibility		Evidence of red cell incompatibility
			* Gram stain and culture results pending

Patient Pre-transfusion DAT:	POLY		IGG		C3	
Patient Post-transfusion DAT:	POLY		IGG		C3	

REACTION CLASSIFICATION

X	* Pending Medical Director Review

RECOMMENDATIONS and COMMENTS

X	* Pending Medical Director Review

COMMENTS: _____

Results called to:		Date / Time	
Testing performed by:		Date / Time	

"+m" = Microscopic "+w" = Weakly Positive NT = Not Tested Neg = Negative

CarterBloodCare
2205 HWY 121
Bedford, TX 76021
(p)817-412-5740
(f)817-412-5749
CLIA#45D0486046
AABB IRL #95

Carter BloodCare

REFERENCE AND TRANSFUSION SERVICES
TRANSFUSION REACTION INVESTIGATION
FINAL REPORT

Patient Name:		Sample Collection Date & Source:	
ID Number:		Date Request Received:	
Requesting Facility:		Diagnosis:	
Ordering Physician:		Patient Date of Birth & Gender:	

UNIT INFORMATION

Unit Number: _____ **Date/Time of Transfusion Reaction:** _____

Component Involved: _____ **Amount Transfused:** _____ **ml**

REACTION DETAILS

☐	☐ Chills present	☐ Nausea/Vomiting	**Other listed below**
☐	☐ Fever	☐ Urticaria / Hives / Rash	
☐	☐ Dyspnea	☐ Hematuria	
	☐ Shock	☐ Back or Chest Pain	
☐	☐ Jaundice		

INVESTIGATION FINDINGS

☐	Clerical checks were performed and found acceptable	☐	Discrepancy noted in Clerical/Visual paper work check
☐	Visual inspection of the pre- and post-sample was normal	☐	Hemolysis present in post transfusion sample
☐	Pre and Post transfusion sample testing resulted in no discrepancies	☐	Discrepancy noted in sample testing
☐	There is no evidence of red cell incompatibility	☐	Evidence of red cell incompatibility
☐	Negative Gram stain (no organisms seen)	☐	Positive Gram Stain Date/Time
☐	Negative culture (no growth)	☐	Positive Culture Date/Time

Patient Pre-transfusion DAT: POLY ☐ IGG ☐ C3 ☐

Patient Post-transfusion DAT: POLY ☐ IGG ☐ C3 ☐

REACTION CLASSIFICATION

☐ Febrile ☐ Allergic ☐ Other, See Comments

RECOMMENDATIONS and COMMENTS

☐ Pre-medication with antipyretics to reduce the incidence of febrile non-hemolytic reactions may be indicated

☐ Pre-medication with antihistamine and/or steroids may be indicated

☐ Symptoms may be due to patient's underlying health conditions, clinical correlation is recommended

Comments _____

Results called to:		Date / Time	
Testing performed by:		Date / Time	
Record reviewed by:		Date / Time	
Report reviewed by the Medical Director on:	L. Sutor, MD G. Paranjape, MD W. Crews, MD T. Nishimoto, MD F. Compton, MD	Date	

"+m" = Microscopic "+w" = Weakly Positive NT = Not Tested Neg = Negative

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Carter BloodCare

TRANSFUSION REACTION INVESTIGATION

NOTE: All fields must be completed or a delay in transfusion reaction investigation may occur.

Infusionist Instructions:

1. Immediately discontinue transfusion. Keep IV line open with normal saline (0.9% sodium chloride) or other FDA approved blood administration solution.
2. Check all forms, labels, and patient identification.
3. Notify attending physician and Carter BloodCare Reference and Transfusion Services.
4. Properly collect and label post-transfusion purple top (EDTA) anticoagulated specimen. Minimum 3 mL sample required.
5. Document all required information in the "Patient Information" section (you may apply a patient sticker).
6. Document all required information in the "Infusionist Report" section.
7. Send samples, blood component container with attached administration set and intravenous solutions, compatibility tag, and this completed form to Carter BloodCare Reference and Transfusion Services STAT.

Patient Information

Patient Name: _____ Facility Name: _____

Identification Number: _____ Ordering Physician: _____

Diagnosis:

Infusionist Report

Unit Number(s): _____

Component(s) Involved: _____ Amount(s) Transfused: _____

All forms, labels and patient identification have been verified. ☐ Yes ☐ No

Date/Time Transfusion Started: _____ Date/Time of Reaction: _____

Date/Time Transfusion Stopped: _____ Infusionist: _____

Person Completing Form: _____ Date/Time: _____

Pre-Transfusion	Post-Transfusion	Patient Symptoms
Temperature: _____ °F	Temperature: _____ °F	☐ Chills ☐ Nausea
Pulse: _____	Pulse: _____	☐ Fever ☐ Urticaria
Blood Pressure: _____	Blood Pressure: _____	☐ Dyspnea ☐ Hematuria
O_2 Saturation: _____	O_2 Saturation: _____	☐ Shock ☐ Back or Chest Pain
Chest X-Ray Findings (if performed): _____	Chest X-Ray Findings (if performed): _____	☐ Jaundice ☐ Other

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