LifeStream
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Serious Adverse Events Reporting Form

Purpose: When a transfusion fatality or other serious, unexpected adverse event occurs that is suspected to be related to an attribute of a donor or a unit, the collecting facility shall be notified immediately and subsequently in writing. – From AABB Standards for Blood Banks and Transfusion Services, Current Edition.

To report a potential adverse event contact Hospital Services/Product Management: (909) 386-6829

Date of Reaction:	Recipient ID:	DOB:
Primary Diagnosis:		Gender: M ☐ F ☐

Reporting Facility:	
Attending Physician:	Phone:
Transfusion Service Medical Director:	Phone:

Date/Time of reaction:_____

Fatality? Yes ☐ No ☐ If yes, date/time of death: _____

Suspected Cause of Reaction/ Best classification

☐ Transfusion-related acute lung injury (TRALI) ☐ Septic reaction
☐ Hemolytic reaction ☐ Severe Allergic Reaction ☐ Other _____

Transfusion History

Has the patient had previous transfusion reactions? Yes ☐ No ☐

If yes, describe: _____

Please check the findings below that you consider to be related to the transfusion. (Select all that apply):

Cardiovascular:	**Cutaneous:**	**Respiratory:**
☐ Blood Pressure Decrease ☐ Shock	☐ Edema ☐ Flushing ☐ Jaundice ☐ Other rash ☐ Pruritus (itching) ☐ Urticaria (hives)	☐ Bilateral infiltrates on chest X-ray ☐ Bronchospasm ☐ Cough ☐ Hypoxemia ☐ Shortness of breath
Hemolysis/Hemorrhage:		
☐ Disseminated intravascular coagulation ☐ Hemoglobinemia ☐ Positive antibody Screen		
Generalized:	**Renal:**	**Pain:**
☐ Chills/rigors ☐ Fever ☐ Nausea/vomiting	☐ Hemoglobinuria ☐ Oliguria	☐ Abdominal pain ☐ Back pain ☐ Flank Pain ☐ Infusion site pain

☐ Other Symptoms (describe):_____

Describe condition of patient, what treatments were performed and response to treatment at the time of this report. Please include patient's current status and any pertinent medical history:

_____

_____

_____

_____

If TRALI is suspected:

Is a refrigerated plasma or serum patient sample and/or remaining blood product available for further testing if necessary? Yes ☐ No ☐ N/A ☐

Was a post-transfusion chest X-ray done? Yes ☐ No ☐ N/A ☐

If yes, what was the interpretation? _____

If SEPSIS is suspected:

Was the blood component tested for bacterial contamination? Yes ☐ No ☐ N/A ☐

If yes, were cultures positive? Yes ☐ No ☐ N/A ☐

Culture results: _____

Were patient blood cultures done? Yes ☐ No ☐ N/A ☐

If yes, were cultures positive? Yes ☐ No ☐ N/A ☐

Culture results: _____

If SEVERE ALLERGIC REACTION is suspected:

Has the patient been tested for IgA deficiency? Yes ☐ No ☐ N/A ☐

If yes, results: _____

Please list below the components that you suspect are involved in the current reaction/ use separate paper if needed for additional components:

Unit Number	Component Type	Transfusion Date/Time	Volume given

Were any non-LifeStream components transfused? Yes ☐ No ☐

If yes, has the supplier been informed? Yes ☐ No ☐ N/A ☐

_____ _____

Signature, Transfusion Service Medical Director Date

Fax completed form to: (909) 386-6817 Attention: Medical Surveillance

For LifeStream Use Only

Date/Time Received: _____ **Case Report Number:** _____

Evaluation initiated for:

☐ Transfusion-related acute lung injury (TRALI) ☐ Septic reaction ☐ Other: _____

Medical Director evaluation and orders: