

Case Number: _____

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	Volume In: _____	<i>Is Input & Output Record attached?</i>	
<i>Previous 24 Hours</i>	Volume Out: _____	<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-100-F-01).

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: _____

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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	

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: _____