Suspected Transfusion Related Acute Lung Injury (TRALI) Report Form

(Report other types of adverse events on the *Recipient Transfusion/Infusion Event Report Form*)
(Use the *Suspected Transfusion Related Acute Lung Injury (TRALI) Samples Requisition Form* for sample, ordering, and shipping requirements)

TRANSFUSION SERVICE – Please complete the following

(Transfusion Service Physicians – Please complete page 2)

Date of Report: _____ Name of Reporting Hospital: _____

Date of Reaction: _____

Patient's Name: _____ MR #: _____

Patient's Age: _____ ☐ Male ☐ Female Admitting Diagnosis: _____

Transfusion Service Medical Director: _____

Contact Name/Phone & Fax Numbers: _____

Attending Physician Name & Phone Number: _____

Note: BCW Physicians are available for consultation if desired.

Unit Information:

Unit #	Product Type	Date of Transfusion	Transfusion Start Time	Transfusion End Time

Vital Signs (Pre Tx): BP ____ P ____ R ____ T ____ Time _____ **Patient Surviving? ☐ Yes ☐ No**

Vital Signs (Post Tx): BP ____ P ____ R ____ T ____ Time _____

Time of Onset of Symptoms _____ Within 6 hours of completion of transfusion? ☐ Yes ☐ No

TRANSFUSION SERVICES INSRUCTIONS

Field	Action
Date of Report	Document the date of the report.
Date of Reaction	Document the date of the reaction.
Name of Reporting Hospital	Document the name of the hospital filing the report.
Patient's Name	Document the patient's name.
MR #	Document the patient's medical record number.
Patient's Age, Male/Female	Document the patient's age and designate male or female.
Admitting Diagnosis	Document the patient's admitting diagnosis.
Transfusion Service Medical Director	Document the Transfusion Service Medical Director's name.
Contact Name/Phone & Fax Numbers	Document a contact name, phone and fax number.
Attending Physician Name & Phone Number	Document the name and phone number of the patient's physician.
Unit Information	For each transfusion, document the unit number, product type, date of transfusion, transfusion start time and end time in the table.
Vital Signs / Patient Surviving (Blood pressure, Pulse, Respiration, Temperature, Time)	Document the Pre and Post transfusion vitals and check the appropriate box for Patient Surviving.
Time of Onset of Symptoms / Within 6 hours of completion of transfusion?	Document the time of the onset of symptoms and indicate whether they were within 6 hours of completion of transfusion.

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TRANSFUSION SERVICES PHYSICIAN – Please complete the following

(Transfusion Service – Please complete page 1)

Patient's Name: _____ MR #: _____

Pulse Ox (SPO_2) _____% on ☐ Room Air or ☐ Other _____

Patient transferred to ICU? ☐ Yes ☐ No **Patient intubated?** ☐ Yes ☐ No

☐ O_2 _____ (amount) via _____ (type) PaO_2/FiO_2 (if available) _____

Chest X-Ray: Date/Time _____ WBC Count (if available) _____

Results _____

_____

Evidence of circulatory overload? ☐ Yes ☐ No BNP Done? ☐ No ☐ Yes, Results _____

Normal Range _____

Evidence of respiratory complications/problems prior to transfusion? ☐ Yes ☐ No

Risk factors for Acute Lung Injury other than Transfusion? ☐ No ☐ Yes, check all that apply

☐ Aspiration ☐ Pneumonia ☐ Toxic inhalation ☐ Lung contusion ☐ Near drowning

☐ Severe sepsis ☐ Shock ☐ Multiple Trauma ☐ Burn injury ☐ Acute pancreatitis

☐ Recent cardiopulmonary bypass ☐ Drug overdose

Comments:

_____

_____

_____

Clinical Symptoms observed in some TRALI cases, check all that apply:

☐ Dyspnea ☐ Fever ☐ Hypotension ☐ Tachypnea ☐ Tachycardia ☐ Frothy endotracheal aspirate

Comments:

_____

_____

_____

For BloodCenter Use Only

BloodCenter On-Call Physician Notified? ☐ Yes ☐ No

BloodCenter Physician Name: _____

_____

Suspected Transfusion Related Acute Lung Injury (TRALI)
Samples Requisition Form

PERSON COMPLETING REQUISION	CLIENT INFORMATION
	BloodCenter of Wisconsin (Client #9520) **Donor Management Department** **638 N. 18th Street** **Milwaukee, WI 53233** **Ph: (414) 937-6209 Fax: (414) 937-6409**
PHYSICIAN	

PATIENT/SAMPLE INFORMATION

Patient/Sample Name: Last First MI

MR #: Accession #:

DOB: mm/dd/yyyy Gender: ☐ M ☐ F Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other

Specimen Type: ☐ Whole Blood ☐ Other _____ Draw Date: mm/dd/yyyy

Anticoagulant: ☐ EDTA ☐ Other _____ Draw Time:

PATIENT DRAWING INSTRUCTIONS

(Samples will be accepted 8:00am Monday – noon Friday)

1. Draw two 7ml EDTA (lavender top) tubes of whole blood from the patient.
2. Individually label tubes with:
   - Full name of individual
   - Date of draw
   - Time of draw

Important:

- Samples cannot be accepted after any exposure to an environment in which HLA genes are amplified. (This precaution is essential to avoid contamination of samples with DNA that could alter test result results.)
- Contact laboratory for pediatric drawing requirements or low white cell drawing requirements

SHIPPING INSTRUCTIONS

Sample must remain at room temperature during storage and shipment. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations.

Shipping Address: **Client Services/Histocompatibility Laboratory**
BloodCenter of Wisconsin
638 N. 18th Street
Milwaukee, WI 53233-2121
Ph: 1 (800) 245-3117 ext. 6396

TEST ORDER INFORMATION

☒ HLA-ABC Low Resolution (2402)
☒ HLA-DRB/DQB1 Typing (2409)
☐ Other _____

Note: This requisition is for patients being evaluated for TRALI.

FOR BLOODCENTER USE ONLY

	___ CITP ___ EDTB ___ ACP ___ CITB ___ Other _____	Opened By _____ Entered By _____ Reviewed By _____ Labeled By _____