Recipient Complications – Transfusion Reaction Case Report

INSTRUCTIONS:
For a transfusion reaction that is suspected to be the result of an attribute specific to the donor or the blood product, complete this form and send it, along with any supporting documentation*, to the appropriate blood supplier.

For units collected or provided by the Red Cross, send the form to the Donor and Client Support Center (DCSC) using the fax or email information provided below. For questions or to consult with a Red Cross physician, please call the phone number below.

If the reaction resulted in a fatality, then also **report the fatality to the FDA as soon as possible**.

Timely reporting is vital to prevent the possible transfusion of other products collected from the same donor or donors.

**Supporting documentation may include copies of the following:*

- *The form used and completed in the internal hospital work-up*
- *Physician notes regarding the reaction, including admission and discharge information, as applicable*
- *For suspected TRALI and TACO reactions, pre- and post-transfusion chest x-ray reports*
- *For suspected sepsis cases, patient and product culture results (preliminary, pending, and final)*
- *For suspected allergic reactions, an allergy and medication list.*

DCSC contact information	fax #: 1-888-719-3535	phone #: 1-866-236-3276
	email: VFaxForDCSC@redcross.org	

Recipient Complications – Transfusion Reaction Case Report	
Reporting Health Care Facility Information	
Name	
Address:	
Report date:	

Section I: Clinical Information			
Recipient/Patient Information:			
Recipient ID (patient #):		Age or DOB:	Gender: ☐ Female ☐ Male
Primary diagnoses:			
Attending physician:			
Phone:		Email:	
Transfusion service medical director:			
Phone:		Email:	
Contact for additional information:			
Phone:		Email:	
Date of reaction:		**Time:**	☐ AM ☐ PM
Transfusion–related fatality?		☐ No ☐ Yes ► Date and time of death: If yes, will autopsy be performed? ☐ No ☐ Yes	

Reaction Vital Signs

Indicate which of the following developed during or within 6 hours following transfusion. Check all that apply. *(The signs/symptoms of a septic reaction may be delayed for as long as **24 hours** post transfusion).*

		Pre-Transfusion	During Reaction	Post-Transfusion
	Date and time noted			
☐	Fever (≥39°C or ≥2°C rise)	°C/°F	°C/°F	°C/°F
☐	Blood pressure, **drop** in systolic >30 mmHg	mmHg	mmHg	mmHg
☐	Blood pressure, **rise** in systolic >30 mmHg	mmHg	mmHg	mmHg
☐	Hypoxemia (PaO_2<60, O_2 sat. <90%)	%	%	%
☐	Rapid breathing (>28/min)	bpm	bpm	bpm
☐	Tachycardia (>120/min or >40/min rise)	bpm	bpm	bpm

FOR RED CROSS USE ONLY		
	Case ID number:	
	Date report received:	

Recipient Complications -
Transfusion Reaction Case Report

FOR RED CROSS USE ONLY
Case ID number:

Section I: Clinical Information (continued)

Risk Factors for Acute Lung Injury (Check all that apply)					
☐	Acute pancreatitis	☐	Diffuse alveolar damage	☐	Pulmonary hemorrhage
☐	Acute respiratory Distress Syndrome (ARDS)	☐	Disseminated intravascular coagulation	☐	Radiation to thorax
☐	Amiodarone	☐	Drug overdose	☐	Renal failure
☐	Aspiration	☐	Lung contusion	☐	Severe sepsis
☐	Burn	☐	Massive blood transfusion	☐	Shock
☐	Cardiopulmonary bypass	☐	Multiple trauma	☐	Toxic inhalation
☐	Chemotherapy	☐	Near drowning	☐	Upper airway obstruction
☐	COVID-19 related respiratory disease	☐	Pneumonia	☐	Volume overload
☐	Other risk factors/additional comments:				

Additional signs/ symptoms					
☐	Abdominal pain	☐	Hematuria	☐	Nausea or vomiting
☐	Bronchospasm/wheezing	☐	Hemoglobinuria	☐	Pulmonary edema
☐	Cardiac arrhythmia	☐	Jugular venous distension	☐	Rigors
☐	Chest pain	☐	Lumbar pain	☐	Other
Describe each additional symptom noted above in more detail:					

Medications/Treatments Indicate which of the following were administered. Check all that apply.			
☐ Acetaminophen	☐ Bronchodilators	☐ Epinephrine	☐ Oxygen supplementation
☐ Antihistamines	☐ Diuretics	☐ Intubation/ventilatory support	☐ Steroids
☐ Other (specify):			

FOR RED CROSS USE ONLY
Case ID number:

Section II: Transfusion History

Did the patient receive any non-Red Cross-provided products? ☐ No ☐ Yes

Did the Red Cross perform the compatibility testing of record? ☐ No ☐ Yes

List all products transfused in the 24 hours prior to the transfusion reaction and indicate whether unit is suspected to be involved in the reaction. *(Attach additional sheets as needed)*

Unit number	Product name or code	Transfusion Date	Transfusion Time	Unit modified*	Volume transfused	Residual product available	Unit suspected as involved
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	
				☐ No ☐ Yes		☐ No ☐ Yes	

*For any unit modified, use the space below to identify the unit and provide a brief description of the modification, for example: pooled, aliquoted, warmed, irradiated, washed, leukocyte-reduced by filtration

Please hold any residual product pending additional instructions by Red Cross staff.

Recipient Complications -
Transfusion Reaction Case Report

FOR RED CROSS USE ONLY
Case ID number:

Section II: Transfusion History (continued)

Previous transfusion history in this patient (summarize, including types of products and nature of prior reactions):

Was a post-transfusion chest X-ray performed? *If yes, please attach copy of radiology report.*	☐ No ☐ Yes ► Result:

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

Routine transfusion reaction workup		or ☐ Not done	
Clerical check of transfusion (right unit, right recipient?):	☐ Correct	☐ Incorrect	
Appearance of returned blood bag and contents:	☐ Normal	☐ Abnormal	☐ Not returned
Appearance of returned solutions, tubing, and filters:	☐ Normal	☐ Abnormal	☐ Not returned
Describe any problems:			

Confirmation of compatibility

	Pre-transfusion	**Post-transfusion**
ABO/RH type		
Antibody screen		
Crossmatch (if applicable)		
Direct antiglobulin test		
Other		

Special transfusion reaction workup		or ☐ Not done
☐	HLA/HNA Testing *(If TRALI is suspected, please save a EDTA (purple or pink) patient sample*	
	Recipient HLA type:	Recipient HNA type:
	Recipient HLA/HNA antibody status:	
	Donor HLA/HNA antibody result (if performed):	
	Donor HLA type (if available)	
☐	Other special studies of blood products performed; identify: *(For example, measurement of IgA, red cell antibody titers, red cell phenotyping, measurement of free hemoglobin, or supernatant potassium)*	

Recipient Complications -
Transfusion Reaction Case Report

FOR RED CROSS USE ONLY
Case ID number:

Section II: Transfusion History (continued)

For potential septic reactions due to bacterial contamination of the blood product:

Residual product/blood bag

Sample source:	☐ Bag	☐ Segment	☐ Infusion set/tubing
Sample collection:	☐ Aseptic	☐ Clean	☐ Retrieved from trash
Gram stain:	☐ Negative	☐ Not done	☐ Positive
Culture:	☐ Negative	☐ Not done	☐ Positive

Patient blood cultures

Pre-transfusion	☐ Not done	Date:	☐ Negative ☐ Positive for:
Post-transfusion	☐ Not done	Date:	☐ Negative ☐ Positive for:

Other information

Does patient have history of fever or other infections related to his/her underlying medical condition? ☐ Y ☐ N

Did patient have absolute neutropenia (neutrophil < 500 /µl) prior to transfusion? ☐ Y ☐ N

What other event could explain the findings in this patient other than the transfusion?

☐ Sepsis	☐ Drug reaction	☐ Volume overload
☐ Heart failure	☐ Hemorrhagic shock	☐ Allergic or anaphylactic reaction
☐ Other:		

Transfusion Service: Medical Director's Summary

Suspect Cause: (check appropriate box)

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

From your perspective, what is the likelihood that the transfusion caused this event?

☐ Certain	☐ Likely	☐ Possible	☐ Cannot exclude	☐ Unlikely

Transfusion Service Medical Director Name (print):	
Signature/Date:	