

# REPORT OF TRANSFUSION COMPLICATION

QIR#
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PATIENT INFORMATION			
Patient Name or MR #		Date of Birth	
Hospital/Office	Phone	Current Attending Physician	
Diagnosis at time of transfusion			
Suspect possible			
<input type="checkbox"/> Transfusion transmitted disease: _____; Patient <input type="checkbox"/> was not <input type="checkbox"/> was tested prior to transfusion. Test date: _____ Results: _____			
<input type="checkbox"/> TRALI: Onset (start date and time) of reaction (usually within 6 hours) _____			
<input type="checkbox"/> bilateral diffuse infiltrates on CXR <input type="checkbox"/> pre-existing lung injury <input type="checkbox"/> hypoxemia			
<i>NOTE: FBC will attempt to test the donors identified below in the Transfusion Information section</i>			
<input type="checkbox"/> Other: _____			
Clinical and Laboratory data upon which diagnosis is based (include post transfusion disease marker testing, symptoms, etc.)			
TRANSFUSION INFORMATION			
<b>Reporting Facility:</b> Indicate from your records the blood products administered			
Unit Number	Component	Date Transfused	For TRALI Reactions Only Start time of transfusion
Report date: _____			
Reported by: _____			
Name	Title	Facility	
Contact phone #	Fax #	Email address	

**FAX completed form to Florida's Blood Centers, Quality Assurance Unit (407) 248-5045**

