REPORT OF SUSPECTED ADVERSE REACTION DUE TO CONTENT OF PRODUCT(S)

Case # _____ Initiated By: _____
Name/Date

Suspected Complication: Hemolytic Reaction TRALI
Bacterial Contamination Other_____

Date/Time of Report: _____ Hospital Staff's Name: _____

Reporting Facility: _____ Reporting Physician: _____

Patient Name/ ID: _____

DOB: _____ M / F Patient's Blood Type: _____

Description of Incident/ Symptoms: _____

_____

_____

Other etiologies being investigated_____ Chest X-ray? Y Result: _____ N

Suspected Product(s):

Unit #	Component	Blood Type	Exp Date	Date/Time Issued	Date/Time Reaction Noted
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Additional Information

Patient Diagnosis: _____ Reason for transfusion: _____

Physical location of patient upon reaction_____ Transferred to ICU? Y / N

If in OR, surgical procedure performed? _____ Current status of patient_____

Previous Transfusions? Y / N (If Y, dates/products) _____

If Y, Previous Reactions Reported? _____

Results of the Transfusion Service Reaction Workup:

Pre-Transfusion Sample: ABO/Rh _____ ABSC _____ DAT _____

Post Transfusion Sample: ABO/Rh_____ ABSC _____ DAT _____ Hemolysis Noted? _____

Other Notes: _____

_____

SEE REVERSE SIDE FOR DOCUMENTATION OF BBD INVESTIGATION

Blood Bank of Delmarva, Inc. * 100 Hygeia Drive * Newark, DE 19713-2085

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Results of Investigation: