ADVERSE TRANSFUSION EVENT REPORT

DOCUMENT ID CHF104 VERSION 1.2 EFFECTIVE DATE 10/11/18

Patient Name _____ MR# _____
DOB _____ Sex _____
Address _____ City _____ State _____ Zip _____
Hospital _____ Physician _____
Diagnosis_____ Pre-transfusion Admission Date _____
Report Completed By _____ Date _____

Instructions to Laboratory
When a patient experiences an adverse transfusion event, please notify Marsh by calling Donor Processing at (423) 408-7531. Fax this completed form to (423) 408-7542. Do not use this form to report mild reactions such as minor rashes or itching.

SECTION I

Adverse Event

___TRALI (use TRALI Report Form)
___Anaphylactic reaction
___Bacterial contamination
___Hemolytic Transfusion Reaction
____Other (explain)_____

___Suspected Transfusion-Transmitted Disease (specify)_____
(hepatitis, HIV, etc.)
Complete Section II if transfusion-transmitted disease

Did a fatality occur?____No ___Yes reported to CBER on _____
date

Unit Number(s) of Blood Product(s) Transfused

Unit Number	Date/Time Transfused	Product	Comments

SECTION II

COMPLETE IF TRANSFUSION-TRANSMITTED DISEASE

Hepatitis (type) _____ HIV _____ Other (specify) _____

Disease Symptoms/Date _____
_____
_____

Clinical Evidence _____
_____
_____
_____

Additional History (previous transfusions, other possible contacts with disease, current medications, etc.) _____
_____
_____
_____
_____

Laboratory Findings	
Test	**Result**

For Donor Center Use Only

Medical Director Evaluation _____
_____
_____
_____
_____
_____
_____
_____

Medical Director Signature _____ Date _____