Report of Suspected Transfusion-Related Acute Lung Injury (TRALI)

REPORT DATE: _____/_____/_____ REPORTING FACILITY: ___________________________________

PATIENT INFORMATION			
PATIENT NAME:	**LAST**	**FIRST**	**MIDDLE INITIAL**
Patient's Diagnosis at time of transfusion:			
Date and time of Onset of symptoms: Date (/ /) Time:			

BLOOD COMPONENTS ADMINISTERED (within 6 hours before onset of suspected transfusion-related event)		
Unit Number	**Product**	**Date and Time USED**
		/
		/
		/
		/

TRALI Suspect

(Symptoms Exist)	**RESULTS**		**History of**	**RESULTS**	
	Pre	*Post*		*Yes*	*No*
Fever			Allogeneic Transfusions		
Hypotension or hypertension			Pregnancies (how many)		
Dyspnea			Did the reaction occur within 6 hrs of transfusion?		
Bilateral pulmonary edema			Were recipient samples drawn for possible testing?		
Acute respiratory distress			Was the BNP elevated?		
Hypoxemia					

(continue to next page)

Reporting Physician's Comments:____

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_____________________________________ _____________________________________
Typed or Printed Name of Reporting Physician | Signature of Reporting Physician

Return form to STBTC

MAKE NO ENTRIES BELOW THIS BOX. FORWARD COMPLETED REPORT TO: SOUTH TEXAS BLOOD & TISSUE CENTER by Fax to : (210) 249-4447, ATTN: QUALITY ASSURANCE DEPT.

Medical Director's Evaluation:

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_____________________________________ _____________________________________
Typed or Printed Name of Medical Director | Signature of Medical Director

Date: ___________________________________