



Saskatchewan Transfusion Adverse Event Report Form

Patient Demographics

Please print both sides and place patient identifiers on PAGES 1 & 2

Reporting Facility Name: _____

Phone Number: _____ Fax Number: _____

Diagnosis: _____

Indication for Transfusion: _____

Category (choose one): Hematology/BMT Oncology Medical Surgical

Patient Legal Last Name: _____

Patient Legal First Name: _____

HSN/MRN: _____

Date of Birth (dd/mm/yyyy): _____

Gender: Male Female Unknown

Obstetrics/Gyn/Perinatal Trauma Neonatal/Peds

1. Patient and Blood Component/Product Unique Identifier Verification (Clerical check)

Is the information IDENTICAL on all the following: Patient ID band Issue document/tag Blood component/product label? YES NO
 IF NO, contact TMS/Lab IMMEDIATELY. **Another patient may be at risk.** Date /Time TMS/Lab notified: _____ Person contacted: _____

2. Clinical History (Check all that apply)

- Pre-existing fever (T ≥ 38.0°C before transfusion)
- History or pre-transfusion evidence of hypervolemia
- Immune-compromised (specify): _____
- Transfused under GENERAL anesthesia
- Transfused under REGIONAL anesthesia
- Transfusion pre-medication (specify): _____
- Patient currently prescribed: ACE inhibitor Diuretic Antibiotic(s) (specify): _____
- History of transfusion: No Unknown Yes (within 3 months) Yes (> 3 months)
- History of pregnancies/miscarriages: No Unknown Yes (within 3 months) Yes (> 3 months)

3. Location, Date and Time of Transfusion Reaction

Choose one: ICU ER Medical Ward Surgical Ward OR/Post Anesthesia Care OB/Gyn Outpatient Chronic Care Lab (Serologic)

Date (dd/mm/yyyy)	Time Transfusion Started	Time Reaction Occurred	Time Transfusion Stopped	Time Transfusion Restarted Only upon medical direction	Time Transfusion Completed

4. Vitals & Clinical Signs and Symptoms

Pre-transfusion	Temp: °C (route)	BP:	Pulse:	Resp:	SpO ₂ :	O ₂ Source:
During reaction	Temp: °C (route)	BP:	Pulse:	Resp:	SpO ₂ :	O ₂ Source:
Post-transfusion	Temp: °C (route)	BP:	Pulse:	Resp:	SpO ₂ :	O ₂ Source:

Clinical Signs and Symptoms (Check all that apply; attach medication record, nursing notes, physician notes, and transfusion administration record, if available)

- Fever (Oral T ≥38°C AND ≥1°C rise above baseline temp)
- Nausea/vomiting
- Facial or tongue swelling
- Urticaria (hives)
- Joint/muscle pain
- Wheezing
- Pruritus (itching)
- Back pain
- Hypoxemia: SpO₂ _____% or PaO₂ _____ mm Hg on _____
- Skin rash other than urticarial < ¼ body affected > ¼ body affected
- Chest pain
- Room air
- Room air Supplementary O₂ _____ L/min
- Dyspnea (shortness of breath)
- Heat/pain at IV site
- Hypertension
- Headache
- Dizziness
- Hypotension (SBP drop by ≥ 30mmHg)
- Chills (sensation of cold)
- Jaundice
- Tachycardia (HR rise by > 40bpm)
- Rigors (involuntary shaking)
- Red or brown urine
- Shock
- Flushing
- Oliguria
- Diffuse hemorrhage
- Restlessness/anxiety
- Diffuse hemorrhage

Other relevant clinical information: _____

5. Blood Component/Product(s) and Equipment Information (Attach sheet with additional information if needed)

Blood Component/Product Type	Product ABO/Rh	Unit Number or Lot Number	Expiry Date (dd/mm/yyyy)	Volume Transfused (mL)	Transfusion Rate (mL/min)

Filters or Equipment Used	<input type="checkbox"/> Standard blood filter	<input type="checkbox"/> Other blood filter	<input type="checkbox"/> IV pump	<input type="checkbox"/> Blood warmer	<input type="checkbox"/> Rapid infusion device
	<input type="checkbox"/> Re-infusion device	<input type="checkbox"/> Cell saver	Details: _____		

6. Measures Taken and Notifications

6a. Transfusion Reaction Treatment Measures Taken (Check all that apply)

- None
- Analgesics
- Vasopressors
- ICU
- Other Measures Taken
- Transfusion Stopped
- Antihistamines
- Antibiotics
- Chest X-ray
- Specify: _____
- Transfusion Restarted
- Steroids
- Supplementary O₂
- Patient Blood Culture Ordered
- Antipyretics
- Diuretics
- Mechanical Ventilation
- Product Sent to Lab

6b. Notifications

<input type="checkbox"/> Physician Name: _____	Date/Time: _____	<input type="checkbox"/> TMS/Lab Name: _____	Date/Time: _____
Reported By: _____	Signature: _____	Name (print): _____	Designation: _____
	Facility: _____		Date/Time: _____



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Patient Demographics

Patient Legal Last Name: _____

Patient Legal First Name: _____

HSN/MRN: _____

Date of Birth (dd/mm/yyyy): _____

Gender: Male Female Unknown

TO BE COMPLETED BY THE TRANSFUSION SERVICE/LABORATORY

Testing Lab Name(s): _____

7. Laboratory Investigation and Notifications

7a. History of Previous Transfusion Reactions

None Unknown Yes (within 3 months) Yes (> 3 months)

Type of previous reaction: _____

7b. Investigation Required Lab Clerical Check, Visual Plasma Check; **NO** serological investigation needed DST Level 1 Level 2

7c. Lab Results (attach all reports with the results of completed investigations, where applicable)

Level 1 Investigation	Lab Order #:	Lab Order #:	Level 2 Investigation	Lab Order #:	Lab Order #:
	Pre-transfusion Result	Post-transfusion Result		Pre-transfusion Result	Post-transfusion Result
Lab Clerical Check	<input type="checkbox"/> pass <input type="checkbox"/> fail	<input type="checkbox"/> pass <input type="checkbox"/> fail	DAT	<input type="checkbox"/> negative <input type="checkbox"/> positive	
Visual Plasma Check	<input type="checkbox"/> negative <input type="checkbox"/> positive	<input type="checkbox"/> negative <input type="checkbox"/> positive	ABO/Rh	<input type="checkbox"/> patient <input type="checkbox"/> RBC unit	
DAT		<input type="checkbox"/> negative <input type="checkbox"/> positive	Ab Screen	<input type="checkbox"/> negative <input type="checkbox"/> positive	<input type="checkbox"/> negative <input type="checkbox"/> positive
Patient ABO/Rh			IAT Crossmatch		
<input type="checkbox"/> Investigation for Bacterial Contamination/Sepsis (attach all blood culture reports)		<input type="checkbox"/> Patient	Lab Order #:	Date taken:	<input type="checkbox"/> positive <input type="checkbox"/> negative
		<input type="checkbox"/> Product	Lab Order #:	Date taken:	<input type="checkbox"/> positive <input type="checkbox"/> negative

7d. Notifications / Reports (check and provide details for all that apply)

Facility Risk Management No Yes → Contact Person: _____ Date Reported: _____

CBS or Product Manufacturer No Yes → Contact Person: _____ Date Reported: _____

Health Canada No Yes → Contact Person: _____ Date Reported: _____

Fax SK Adverse Event Report Form to SHR 306-655-0987 or RQHR 306-766-4382

TO BE COMPLETED BY SK TRANSFUSION MEDICINE CONSULTANT OR DESIGNATE

8. Review of Investigation & Conclusion (based on 2007 PHAC definitions)

No transfusion reaction FNH Minor allergic Severe allergic/anaphylactic/anaphylactoid Anaphylactic shock

Incompatible transfusion Intentional Unintentional ABO System Anti-_____ Other System Anti-_____

Acute hemolytic reaction Delayed hemolytic reaction Cause: _____

Delayed serological transfusion reaction (DSTR) Specify new alloantibody(ies) within 28 days of transfusion: Anti-_____

TACO → Diuretics effective TAD PTP TA-GVHD Hypotensive reaction

Blood-borne infection: Bacterial Viral Other (specify): _____

Recipient Specify organism: _____

Donor/product infected Yes No If yes, specify organism: _____

TRALI Possible TRALI → Risk factors: _____

CBS TRALI criteria met (1+2+3+4): CBS TRALI form sent Date: _____

1 Hypoxemia → SpO₂ < 90% on Room Air **or** PaO₂ < 60 mm Hg on Room Air **or** PaO₂/FIO₂ < 300 2 Transfusion within 6 hours of TRALI

3 New Chest X-Ray findings of bilateral infiltrates 4 No evidence of circulatory overload → Diuretics ineffective Ventilation Duration: _____

IVIG headache Aseptic meningitis (IVIG related) Unknown Other (specify): _____

Implication Cause of Transfusion Reaction (if applicable):

Incident (Error/Accident) Patient identification Product related Equipment related Other (specify): _____

9. Relationship, Severity and Outcome of Adverse Reaction

a. Relationship of reaction to transfusion Definite Probable Possible Doubtful Ruled out Not determined

b. Severity (Grade) 1 (non-severe) 2 (severe) 3 (life-threatening) 4 (death) Not determined

c. Outcome Minor or no sequelae Major or long-term sequelae Death Not determined

d. Status of investigation In progress Concluded Cannot be concluded → Reason (specify): _____

10. Comments and Recommendations

11. Conclusion Sign Off

SK TM Consultant Signature: _____ Name (print): _____ Date: _____

For cases reported to Health Canada:
Local TM Medical Director/Pathologist Signature: _____ Name (print): _____ Date: _____

Reportable to PHAC: Yes No

SK TTISS Number: _____ CNPHI Number: _____