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

Medical Services Phone: (713) 791-6216 or (713) 713-6364

Fax Completed Form to Medical Services: (713) 791-7729

Report Date:	Facility Name:		
Address:		City:	
Contact Person:		State:	Zip:
Contact Email:		Phone:	

Section A

Indicate Report Type:	☐ Suspected Transmissible Disease	☐ HCV	☐ HBV	☐ HIV
		☐ Other (specify):		
	☐ Transfusion Related Acute Lung Injury (TRALI)			

Section B

Patient Name:	
Medical Record #:	DOB:
Patient Diagnosis at Time of Transfusion:	

Section C (For Suspected Infection Only)

Results of tests performed that support the suspected transmissible disease:

Section D (For TRALI only)

Provide the documentation and/or reports for the following items. Submissions with incomplete or missing documents may cause delays.

- Complete clinical history (any preexisting/current cardiac, kidney, lung condition)
- Indication for transfusion
- Completed transfusion reaction workup
- Fluid balance 24 hours prior to suspected transfusion reaction.
- Pre- and post-transfusion chest x-ray, if available.
- Pre- and post-transfusion BNP, if available. (Please order BNP if Transfusion Associated Circulatory Overload cannot be ruled out.)

Use the following codes to indicate the component type transfused.			
Code	**Component Type**	**Code**	**Component Type**
WB	Whole Blood	CRYO	Cryoprecipitate AHF
RBC	Red Cells	PLT	Platelets, Pheresis Platelets
Plasma	Plasma, FFP, Pheresis Plasma	Other	Specify: _____

Code	**Unit Number**	**Date Transfused**

Section E		
Physician's Name:	Phone #:	
Address:		
City:	State:	Zip:
Form Completed By:	Date:	