





## Transfusion Associated Adverse Event Report

### Please complete for suspected BACTERIAL CONTAMINATION

Are the following present?
What are the findings in the recipient? - Temp pretransfusion _____ Temp posttransfusion _____ - Temp max 24 hrs prior to transfusion _____
What are the culture results? - Patient culture results (site, organism) _____ - Blood product culture results (time of transfusion, culture, findings) _____
Was blood product hemolyzed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have other infections prior to transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No ..... If yes, please describe:  Additional information:

### Please complete for Transfusion-Associated Graft vs. Host Disease (GVHD)

Possible TA-GVHD
Is the patient immunocompromised ..... <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, please explain:
Did the patient receive non-irradiated cellular blood products within 3 weeks of symptoms ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Were any units directed donations from family members ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Did the recipient receive HLA matched platelets within 3 weeks of symptoms ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient had a bone marrow or organ transplant ..... <input type="checkbox"/> Yes <input type="checkbox"/> No

### Please complete for Posttransfusion Purpura (PTP)

Possible PTP
PTP is usually characterized by a dramatic thrombocytopenia 5-10 days following a blood transfusion in a patient with a history of sensitization to platelet specific antigens by pregnancy or transfusion.
Pretransfusion plt ct/date: _____ Lowest Posttransfusion plt ct/date: _____
History of pregnancy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous history of Neonatal Alloimmune Thrombocytopenia in children ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
History of previous transfusion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Did the recipient receive HLA matched platelets within 3 weeks of symptoms ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient had a bone marrow or organ transplant ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain:
Please attach relevant laboratory values including platelet specific antigens or antibodies.

Mail or Fax to: Medical Director, San Diego Blood Bank  
 3636 Gateway Center Ave, Suite 100 San Diego, CA 92102  
 Fax # 619-220-8416