STOP II TRIAL
BLOOD UNIT FORM

****AFFIX PATIENT LABEL HERE****

COMPLETE SEPARATE FORM FOR <u>EACH UNIT</u> GIVEN DURING A TRANSFUSION VISIT

A1. Person completing form (Name): ________________________________ Initials: ☐☐☐

A2. Date of Transfusion (Month/Day/Year): ____ ___/____ ___/____ ___ ___ ___

A3. Unit Number: ______________________

B1. Blood Product:

☐ 1. HbS negative packed red cells

☐ 2. HbS negative packed red cells reconstituted with → B1.a
- ☐ **1. saline**
- ☐ **2. albumin**
- ☐ **3. plasma**
- ☐ **4. other** → B1.b Specify: ______________

☐ 3. Other → B1.c Specify: ______________________

B2. Was the unit NEGATIVE for the following antigens?

		1. NO	**2. YES**
B2.a	C	☐	☐
B2.b	E	☐	☐
B2.c	Kell	☐	☐

B3. Was the unit known to be negative for any other antigens? ☐ 1. NO ☐ 2. YES ↓

SPECIFY ANTIGEN(S):

B3.a1 ______________________

B3.a2 ______________________

B3.a3 ______________________

B3.a4 ______________________

☐ ML ☐ DE

B4. Was a Third Generation Leukodepletion Filter used? ☐ **1. NO** ☐ **2. YES**

B4.a Filtering Process:

- ☐ A **PRESTORAGE LEUKODEPLETION**
- ☐ B **LEUKODEPLETION IN BLOOD BANK**
- ☐ C **BEDSIDE FILTRATION**
- ☐ D **OTHER**

D1. If other, specify: ______________________

C. TRANSFUSION TYPE AND DELIVERY

C1. Type of transfusion for this unit:

C1.a **Simple** ☐ **1. NO** ☐ **2. YES** → C1.a1 Number of mL in ☐☐☐☐

C1.b **Exchange** ☐ **1. NO** ☐ **2. YES** → C1.b1 Total mL in: ☐☐☐☐

C1.b2 Total mL out: ☐☐☐☐

C1.b3 Method ☐ **1. Manual** ☐ **2. Red Cell Pheresis**

C1.b3.a Delivery

- ☐ **1. Intermittent**
- ☐ **2. Continuous**

C1.b4 Hematocrit of

a. blood transfused (%) ☐☐.☐ ☐ **-1. NOT AVAILABLE**

b. blood removed (%) ☐☐.☐ ☐ **-1. NOT AVAILABLE**

ATTACH COPY OF THE TRANSFUSION TAG FOR THIS BLOOD UNIT.

Signature of Study Coordinator: ______________________ Date: ____ ___/___ ____/___ ___ ___ ___

D. FOR OFFICE USE

D1. Transfusion tag received: ☐ **1.NO** ☐ **2.YES** ☐ ML ☐ DE