

S32r0 Transfusion Reaction Form

Ad Hoc Event ID _____

Visit Date (yyyy/mm/dd): _____

Correction:

Yes

No

Use this form to report transfusion reactions either during treatment or within 15 minutes after completion of treatment.

1. Date of transfusion (yyyy/mm/dd): _____

2. Type of transfusion:

Simple

Modified exchange

Erythrocytapheresis

3. Type of reaction:

Febrile non-hemolytic

Allergic or anaphylactoid

Hemolytic transfusion reaction (HTR)

4. Associated complications:

Hypertension and circulatory overload

Vaso-occlusive

Transient ischemic attack

A descriptive, narrative report of all transfusion reactions is required by the SITT DSMB. Please use the field below to upload your narrative for this transfusion reaction. The narrative must include the Patient ID number and date of the transfusion reaction, followed by a complete description of the occurrence, procedures followed, and outcome.

Staff I.D. #: _____