Name of reporting health care facility

Address

Local Tracking No. _____

BaCon Study No _____
(For use by the Coordinating Organization Only)

Clinical Service
Section I
Complete Relevant Items with Available Information

Recipient identification _____ Age or DOB _____Sex: Female ☐ Male ☐

Underlying diagnosis _____

Indication(s) for transfusion: _____

Location of transfusion (e.g. ICU) _____

Date and time reported _____

Reported by: (name and title) _____

(phone) _____ (Fax) _____

Recipient's physician: _____ Phone no._____

Fatality ☐ Yes ☐ No

If yes, notify transfusion service immediately. _____ (initials of person who notifies transfusion service)

Unit Number or Pool Number	Expiration Date	Bag Lot Number	Involved Component/ Derivative Name	Product Code	Approx. Volume Transfused

Did recipient experience any of the following during or up to 90 minutes after transfusion? *(check box)*

Fever (Temp ≥39° C or ≥2° C rise)	☐ Yes	☐ No	☐ Unk	Tachycardia (Heart rate ≥120/min or ≥40/min rise)	☐ Yes	☐ No	☐ Unk
Rigors (shaking chills)	☐ Yes	☐ No	☐ Unk	Nausea and vomiting	☐ Yes	☐ No	☐ Unk
Shortness of breath (breath ≥ 28 breaths/min)	☐ Yes	☐ No	☐ Unk	Lumbar pain (Lower back pain)	☐ Yes	☐ No	☐ Unk
Rise in systolic blood pressure (≥ 30mm Hg)	☐ Yes	☐ No	☐ Unk	Drop in Systolic blood pressure (≥30mm Hg)	☐ Yes	☐ No	☐ Unk

Collection Facility Information
Name _____
Contact Name _____
Phone _____ Fax _____
Address _____
City, State, Zip _____

Local Tracking No. _____
BaCon Study No _____
(For use by the Coordinating Organization Only)

Transfusion Service
Section II
EVALUATION

Review Section I and complete any missing information

Appearance of returned blood bag and contents: _____

Unit modified in any way? ☐ Yes ☐ No
If yes, how? (check box) ☐ washed ☐ deglycerolyzed ☐ irradiated ☐ leukocyte ☐ filtered
☐ pooled ☐ warmed ☐ other _____
Record place, date, and time modified _____

Have bags and/or segments been retained for further investigation? ☐ Yes ☐ No
If yes, record time/date blood bag was refrigerated _____

	Unit Issued	Transfusion Started	Reaction Began	Transfusion (use appropriate column)	
				☐ Completed	☐ Interrupted
Date					
Time					

Describe transfusion facility investigation, treatment, and recipient response to date: _____

Previous history of transfusion and any reactions: _____

SUSPECTED CAUSE: ☐ Bacterial **if yes, report to Collection Facility**
(check appropriate box) ☐ Hemolytic reaction ☐ TRALI ☐ Other _____
Conclusions: _____

Does this event need further investigation? ☐ **Yes** ☐ **No**

_____
Transfusion Service Medical Director Signature

If yes, go to section III.

Transfusion Service
Section III
INVESTIGATION

Local Tracking No. _____

BaCon Study No _____
(For use by the Coordinating Organization Only)

Complete this table for pooled components only:

Individual Unit Number	Expiration Date	Bag Lot Number	Involved Component/ Derivative Name	Product Code

1. General Recipient Lab Results

	Pretransfusion	Posttransfusion
ABO/Rh	_____	_____
DAT	_____	_____
XM	_____	_____
Ab screen	_____	_____
Other	_____	_____

2. Reaction Potentially Due to Bacterial Contamination (Complete below attach all culture reports)

Blood unit (If possible, obtain sample from blood unit)

☐ Gram stain (positive ≥ 2 organisms per high power field)

Sample source ☐ Bag ☐ Segment ☐ Sample tube ☐ Other _____

Condition of retrieved sample ☐ Aseptic ☐ Trash ☐ Other _____

Date of Gram stain _____

Results _____

☐ Culture

Sample source ☐ Bag ☐ Segment ☐ Sample tube ☐ Other _____

Condition of retrieved sample ☐ Aseptic ☐ Trash ☐ Other _____

Date of Culture _____

Results (organism identification) _____

Method of culture: ☐ Aerobic ☐ Anaerobic

If culture is positive, are isolates available for CDC? ☐ Yes ☐ No

Transfusion recipient

Blood cultures ☐ Pretransfusion _____

(Give date, time, result)☐ ☐ Posttransfusion _____

Antibiotics ☐ Pretransfusion _____

(Give date, time and list)☐ ☐ Posttransfusion _____

Report positive findings to the Collection Facility

Collection Facility
Section IV

Local Tracking No. _____

BaCon Study No _____
(For use by the Coordinating Organization Only)

Age of component (since collection) at time of transfusion: _____

If culture positive, Co-components test results	**RBC**	**PLT**	**CRYO**	**Plasma**	**Other** (list)	
Gram stain						
Culture						

If positive, Save isolates for CDC.

APHERESIS INFORMATION (As pertinent)

* Saline lot number _____
* AC (anticoagulant) lot number _____
* Name of machine manufacturer _____
* Machine model number and serial number _____
* Disposable lot number _____

A. For donor of bacterial contamination blood component (s)

Note: For *Yersinia* culture positive donors, use section IV C.

☐ Donor post-donation follow-up (medical director discretion) ☐ **Yes** ☐ **No**

If yes, complete the following information.

Donor Record Review (note unusual circumstances)_____
_____

Symptoms, if any before donation, list _____
after donation, list _____

Blood culture results and date (**Save isolate(s) for CDC**) _____
_____

Medical Director's assessment of donation _____
_____

☐ Subsequent observation of phlebotomist arm scrub
Observation Date _____
Remedial action required☐ ☐ Yes ☐ No
If yes, follow established SOP.