

REPORT OF SUSPECTED TRANSFUSION RELATED ACUTE LUNG INJURY (TRALI)

Patient Information

Patient Name		Date of Birth	
Attending Physician		Gender	
Patient's Diagnosis		Reason for Transfusion	
Date of Transfusion		Date Reported to CBC	
Reporting Institution		Completed By	

Clinical Presentation (check all that apply)

<p>Symptoms:</p> <input type="checkbox"/> Dyspnea <input type="checkbox"/> Tachycardia <input type="checkbox"/> Hypotension (BP ____/____) <input type="checkbox"/> Hypoxemia O ₂ Sat. _____ PaO ₂ /FiO ₂ _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Frothy endotracheal exudate <p>Chest X-Ray Results: Bilateral infiltrates? <input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged heart? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Other potential contributing factors for acute lung injury.</p> <p>Direct Lung Injury:</p> <input type="checkbox"/> Aspiration <input type="checkbox"/> Pneumonia <input type="checkbox"/> Toxic inhalation <input type="checkbox"/> Lung congestion <input type="checkbox"/> Near drowning <p>Other Confounding Factors:</p> <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Pulmonary edema <input type="checkbox"/> Volume overload	<p>Indirect Lung Injury:</p> <input type="checkbox"/> Severe Sepsis <input type="checkbox"/> Shock <input type="checkbox"/> Multiple trauma <input type="checkbox"/> Burn injury <input type="checkbox"/> Acute pancreatitis <input type="checkbox"/> Cardiopulmonary bypass <input type="checkbox"/> Drug overdose
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Comments:

Treatment of Adverse Reaction:

Time of Reaction: _____ List all units transfused within **6 hours** of adverse reaction (attach additional sheet, if necessary)

Unit Number	Time Transfused	Product	Unit Number	Time Transfused	Product

FOR CBC USE ONLY

Further TRALI Investigation Required YES NO

Comments:

Medical Review Performed By	Sign/Initial		Date	
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Complete form, attach a copy of your institutions Transfusion Reaction Summary Report and submit report by mail or FAX.
 MED.04.F010 Version 5.0 Effective: 02/16/11

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