TRALI Patient Data Form

1. To report a TRALI to Canadian Blood Services (CBS), contact your local CBS Distribution Centre and submit this form to your local CBS Distribution Centre. (Manitoba: Refer to the Manitoba Transfusion Reporting Algorithm).
2. Patient TRALI samples accompanied with a completed lab requisition (http://blood.ca/en/requisitions-and-forms) are to be sent to the National Platelet Immunology Reference Lab (NIPRL) directly or via your local CBS lab. NIPRL does not require this TRALI form.

1. CONTACT INFORMATION	
Patient Name or Initials:	
Identification #:	Institution:
DOB: (yyyy-mm-dd)	Sex: ☐ Male ☐ Female
TRALI Date (yyyy-mm-dd):	TRALI Time (hh:mm):
Physician Name:	Physician Contact:
Name & Contact of Person Completing Form (if different than above):	

2. INCLUSION CRITERIA (must fulfill a, b AND c, otherwise TRALI investigation is NOT warranted)					
a) Reaction within 6 hours of transfusion:	☐ Yes	☐ No			
b) New CXR Findings:	☐ Yes	☐ No	☐ N/A	Bilateral Infiltrate:	☐ Yes ☐ No
c) Hypoxemia	O_2 sat < 90 %	☐ Yes	☐ No	☐ Unknown	
	or pO_2 < 60 mm HG	☐ Yes	☐ No	☐ Unknown	
	or $PaO_2/FIO2$ < 300 mm Hg	☐ Yes	☐ No	☐ Unknown	

3. CLINICAL IMPRESSION OF TRALI							
Suspicion of TRALI Reaction:	Low suspicion (e.g. alternate diagnosis likely) ☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 High suspicion (e.g. definite TRALI)	
Severity of TRALI Reaction:	☐ Non-Severe	☐ Severe	☐ Life -threatening	☐ Death			

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4. PATIENT HISTORY				
Previous Transfusions:	☐ Yes	☐ No	☐ Unknown	Patient ABO:
If yes, prior TACO:	☐ Yes	☐ No		
Pregnancies/Miscarriages:	☐ Yes	☐ No	☐ Unknown	
Describe Principal Diagnosis:				

Underlying Clinical Conditions: *(mark all that apply)*

Lung disease:	☐ Pre-existing ARDS	☐ Pneumonia	☐ Aspiration	☐ Other (specify):	
Surgery:	☐ Cardiac Surgery	☐ Other (specify):		Surgical Date: (yyyy-mm-dd):	
Miscellaneous:	☐ Trauma	☐ Massive Transfusion	☐ Sepsis	☐ Liver Disease	☐ Malignancy (specify):
TACO Risk Factors:	☐ Heart Failure	☐ Prior Myocardial Infarction	☐ Renal Failure	☐ Chronic Anemia	☐ Daily Diuretic Use

Other Conditions (specify):

5. VITAL SIGNS *(please complete the following OR attach your local transfusion reaction reporting form)*

	Pre-Transfusion Time: (hh:mm)	At time of Reaction Time: (hh:mm)	Post Transfusion (if applicable) Time: (hh:mm)
Heart Rate:			
Blood Pressure:			
Temperature:			
Resp. Rate:			
O_2 Sat %:	☐ On O_2 (FiO_2):	☐ On O_2 (FiO_2):	☐ On O_2 (FiO_2):

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6. INVESTIGATIONS (Please complete the following if available AND/OR attach relevant reports)		
	Pre-Transfusion	Post Transfusion
Respiratory Status Within 12 Hours	Please specify if status within past 12 hours was: ☐ Stable ☐ Improving ☐ Worsening ☐ Unknown Additional comments on clinical status 12 hours prior (e.g. oxygen requirements, clinical events, etc):	*Not applicable*
Chest Imaging	☐ Not Available ☐ If available, specify date/time: Please attach reports or describe findings:	☐ Not Available ☐ If available, specify date/time: Please attach reports or describe findings:
ECHO	☐ Not Available ☐ If available, specify date/time: LVEF (%): Other findings:	☐ Not Available ☐ If available, specify date/time: LVEF (%): Other findings:
BNP or NT-proBNP	☐ Not Available ☐ If available, specify date/time: Test type: ☐ BNP ☐ NT-proBNP Result (specify): _____ ☐ Normal ☐ Elevated	☐ Not Available ☐ If available, specify date/time: Test type: ☐ BNP ☐ NT-proBNP Result (specify): _____ ☐ Normal ☐ Elevated
Volume Status	☐ Normal ☐ Increased ☐ Decreased ☐ Unknown	☐ Normal ☐ Increased ☐ Decreased ☐ Unknown
24-hour Fluid Balance	☐ Positive ☐ Negative ☐ Unknown If positive or negative, specify volume:	☐ Positive ☐ Negative ☐ Unknown If positive or negative, specify volume:
CBC	☐ White blood Count ($x10^9$/L): ☐ Neutrophils, absolute ($x10^9$/L): ☐ Not Available	☐ White blood Count ($x10^9$/L): ☐ Neutrophils, absolute ($x10^9$/L): ☐ Not Available
Other Findings		

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7. TREATMENT AND RESPONSE

Diuretics	☐ Yes	☐ No	Effective?	☐ Yes	☐ No	☐ Unknown
Supplemental Oxygen (not intubated)	☐ Yes	☐ No				
Non-invasive ventilation (e.g. BiPAP	☐ Yes	☐ No	Duration (hrs):			
Mechanical ventilation	☐ Yes	☐ No	Duration (hrs):			
Other						

8. OUTCOME AT TIME OF TRALI REACTION REPORT

Ongoing	☐ Yes	☐ No	Time since onset (hrs):
Recovered	☐ Yes	☐ No	Time since recovery (hrs):
Deceased	☐ Yes	☐ No	Date (yyyy-mm-dd):

If deceased: Death due to TRALI? ☐ Yes ☐ Contributing ☐ Uncertain ☐ No

If no or uncertain, indicate cause of death:

9. TRALI – IMPLICATED PRODUCTS/UNITS (transfused within 6 hours of reaction)

Product Type	ABO	Donation/ Pool Number	Date Transfused (yyyy-mm-dd)	Start Time (hh:mm)	End Time (hh:mm)	Volume Transfused (ml) or (<25%, 25%, 50% 75%, all)

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10. HOSPITAL SAMPLE COLLECTION FOR PATIENT INVESTIGATION
Patient TRALI samples accompanied with a completed lab requisition (https://blood.ca/en/requisitions-and-forms) can be sent to the National Platelet Immunology Reference Lab (NIPRL) directly or via your local CBS laboratory. NIPRL does not require this TRALI form. For more information on sample submission, please visit http://www.blood.ca/en/laboratory-services/trali-investigation.

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