TRALI Patient Data Form

1) **To report a TRALI to 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 (https://blood.ca/en/requisitions-and-forms) are to be sent to the National Platelet Immunology Reference Lab (NPIRL) directly or via your local CBS lab. NPIRL does not require this TRALI form.

1. CONTACT INFORMATION	
Patient Name or Initials:	
Identification Number:	Institution:
DOB (dd/mmm/yyyy):	Sex: ☐ Male ☐ Female
TRALI Date (dd/mmm/yyyy):	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/FIO_2 < 300 mm Hg ☐ Yes ☐ No ☐ Unknown

3. CLINICAL IMPRESSION OF TRALI REACTION

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

4. PATIENT HISTORY

Previous Transfusions ☐ Yes ☐ No ☐ Unknown If yes, prior TACO? ☐ Yes ☐ No | Patient ABO: _____

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 (dd/mmm/yyyy): _____
- 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):

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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 (FiO2): _____	_____ ☐ On O_2 (FiO2): _____	_____ ☐ On O_2 (FiO2): _____

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 to recovery (hrs): _____			
Deceased	☐ Yes	☐ No	Date (dd/mmm/yyyy): _____			
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 (dd/mmm/yyyy)	Start Time (hh:mm)	End Time (hh:mm)	Volume Transfused (mL) or (<25%, 25%, 50%, 75%, all)

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 (NPIRL) directly or via your local CBS laboratory. NPIRL does not require this TRALI form. For more information on sample submission, please visit https://www.blood.ca/en/laboratory-services/trali-investigation.

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