

# 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: <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	
b) New CXR Findings <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Bilateral Infiltrate <input type="checkbox"/> Yes <input type="checkbox"/> No
c) Hypoxemia	O <sub>2</sub> sat < 90 % <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	or pO <sub>2</sub> < 60 mm Hg <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	or PaO <sub>2</sub> /FIO <sub>2</sub> < 300 mm Hg <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

3. CLINICAL IMPRESSION OF TRALI REACTION	
Suspicion of TRALI Reaction:	Low suspicion (e.g. alternate diagnosis likely) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 High suspicion (e.g. definite TRALI)
Severity of TRALI Reaction:	<input type="checkbox"/> Non-Severe <input type="checkbox"/> Severe <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death

4. PATIENT HISTORY	
Previous Transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, prior TACO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient ABO: _____	
Pregnancies/Miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Describe Principal Diagnosis:	
Underlying Clinical Conditions (mark all that apply):	
- Lung disease: <input type="checkbox"/> Pre-existing ARDS <input type="checkbox"/> Pneumonia <input type="checkbox"/> Aspiration <input type="checkbox"/> Other (specify): _____	
- Surgery: <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Other (specify): _____ Surgical Date (dd/mmm/yyyy): _____	
- Miscellaneous: <input type="checkbox"/> Trauma <input type="checkbox"/> Massive Transfusion <input type="checkbox"/> Sepsis <input type="checkbox"/> Liver Disease <input type="checkbox"/> Malignancy (specify): _____	
- TACO Risk Factors: <input type="checkbox"/> Heart Failure <input type="checkbox"/> Prior Myocardial Infarction <input type="checkbox"/> Renal Failure <input type="checkbox"/> Chronic Anemia <input type="checkbox"/> 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 <sub>2</sub> Sat %:	<input type="checkbox"/> On O <sub>2</sub> (FiO <sub>2</sub> ): _____	<input type="checkbox"/> On O <sub>2</sub> (FiO <sub>2</sub> ): _____	<input type="checkbox"/> On O <sub>2</sub> (FiO <sub>2</sub> ): _____

## 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: <input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> Unknown  Additional comments on clinical status 12 hours prior (e.g. oxygen requirements, clinical events, etc.):	<i>Not applicable</i>
Chest Imaging	<input type="checkbox"/> Not available <input type="checkbox"/> If available, specify date/time: _____ Please <u>attach reports</u> or describe findings:	<input type="checkbox"/> Not available <input type="checkbox"/> If available, specify date/time: _____ Please <u>attach reports</u> or describe findings:
ECHO	<input type="checkbox"/> Not available <input type="checkbox"/> If available, specify date/time: _____ LVEF (%): _____ Other findings:	<input type="checkbox"/> Not available <input type="checkbox"/> If available, specify date/time: _____ LVEF (%): _____ Other findings:
BNP or NT-proBNP	<input type="checkbox"/> Not available <input type="checkbox"/> If available, specify date/time: _____ Test type: <input type="checkbox"/> BNP <input type="checkbox"/> NT-proBNP Result (specify): _____ <input type="checkbox"/> Normal <input type="checkbox"/> Elevated	<input type="checkbox"/> Not available <input type="checkbox"/> If available, specify date/time: _____ Test type: <input type="checkbox"/> BNP <input type="checkbox"/> NT-proBNP Result (specify): _____ <input type="checkbox"/> Normal <input type="checkbox"/> Elevated
Volume Status	<input type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Unknown	<input type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Unknown
24-hour Fluid Balance	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown If positive or negative, specify volume: _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown If positive or negative, specify volume: _____
CBC	<input type="checkbox"/> White blood count (x10 <sup>9</sup> /L): _____ <input type="checkbox"/> Neutrophils, absolute (x10 <sup>9</sup> /L): _____ <input type="checkbox"/> Not available	<input type="checkbox"/> White blood count (x10 <sup>9</sup> /L): _____ <input type="checkbox"/> Neutrophils, absolute (x10 <sup>9</sup> /L): _____ <input type="checkbox"/> 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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