

**Report of Suspected
Transfusion Transmitted Infection (TTI)
&
Transfusion Related Acute Lung Injury (TRALI)**

Risk Management Ph#: 713-791-6345
Fax Completed Form to the Risk Management Department to: (713)791-1615

Report Date:	Facility Name:		
Address:			
City:		State:	Zip:
Contact Person:		Phone:	
Section A			
Indicate Report Type:	<input type="checkbox"/> Suspected Transfusion Transmitted Infection (TTI)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HCV <input type="checkbox"/> HBV <input type="checkbox"/> HIV
	<input type="checkbox"/> Transfusion Related Acute Lung Injury (TRALI)	<input type="checkbox"/> Malaria	<input type="checkbox"/> Other (specify):
Section B			
Patient's Name:			
Patient's Medical Record #:			
Patient's Diagnosis at Time of Transfusion:			
Results of applicable tests performed that support the suspected TTI (if applicable):			
Section C (for TRALI only)			
Check the appropriate boxes that supports the suspected TRALI reaction:			
<input type="checkbox"/> Hypoxemia	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Bilateral lung infiltrates	
<input type="checkbox"/> Acute onset (≤ 6 hrs.)	<input type="checkbox"/> Fever	<input type="checkbox"/> Absence of left atrial HTN	
Include clinical synopsis of patient pre/post transfusion: vital signs, O ₂ saturation, results of chest radiograph, time from transfusion to onset of reaction, lab tests performed, presence/absence circulatory overload.			
The transfusing facility may wish to retain a pre-transfusion patient sample for HLA antigen/antibody testing, if needed.			
Section D			
Reporting Physician's Name			Phone #: <input type="text"/>
Address:			
City:		State:	Zip:
Form Completed By:		Date:	

