



Report of Suspected Transfusion-Associated Sepsis

LifeSouth Community Blood Centers

For Internal Use Only

Case File Number:

Form Completed by (Name, Job Title):		Date Completed:
Phone #:	Facility:	
Patient Name:		Patient ID #:

Date and time of onset of symptoms: / / at : am pm

Signs and Symptoms

- Fever
- Chills, rigors
- Hypotension, shock
- Tachycardia
- Dyspnea
- Nausea/vomiting
- DIC
- Other; specify: _____

Vital Signs

	Pre-Transfusion		Post-Transfusion	
	Date/Time:		Date/Time:	
Temperature				
Heart Rate				
Blood Pressure				

Results of Investigation

- Blood bag returned.
 - Abnormal appearance, specify: _____
- Gram stain; copy of lab report attached.
- Culture; copy of lab report attached.
- Other testing performed; copy of lab report attached.
- Patient blood cultures pre-transfusion; copy of lab report attached.
- Patient blood cultures post-transfusion; copy of lab report attached.
- Other cultures; copy of lab report attached.
- No additional testing performed.

FAX TO (352) 224-1778 • CONFIRM FAX RECEIVED AT (888) 795-2707
 AFTER NORMAL BUSINESS HOURS (9AM TO 5PM ET, M-F) FAX TO (352) 334-1029 • CONFIRM FAX RECEIVED AT (352) 334-1028