Clear Fields

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:	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