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| ***Please complete this form electronically if possible*** |
| **Recipient Details** (pre-printed label may be used) |
| Family Name  | First Name | National Health Index No.  | Height (cm) | Weight (kg) |
| Click here | Click here | XXX0000 | 000 | 000 |
| Hospital | Location | Date of Birth | Sex  | Pregnant |
| Click here | [ ]  Inpatient [ ]  Outpatient [ ]  Other: Click here  | dd/mm/yyyy | [ ]  Male[ ]  Female | [ ]  Yes[ ]  No or N/A |
| **Primary Diagnosis** | **Indication for Fractionated Blood Product**  |
| Click here to enter text. | Click here to enter text. |
| **Relevant medical history** *(including surgery, allergies - add a separate page if necessary)* |
| Click here to enter text. |
| **Suspected or Implicated Fractionated Blood Product(s)**  |
| **Blood Product** | **Dose / Vol Prescribed** | **Route** | **Date****Given** | **Start time** | **Dose / Vol****Given** | **Stop time** | **Batch Number(s)** |
| Click here | 0000 | XX | dd/mm/yyyy | HH:MM | 0000 | HH:MM | Click here |
| Click here | 0000 | XX | dd/mm/yyyy | HH:MM | 0000 | HH:MM | Click here |
| Click here | 0000 | XX | dd/mm/yyyy | HH:MM | 0000 | HH:MM | Click here |
| Click here | 0000 | XX | dd/mm/yyyy | HH:MM | 0000 | HH:MM | Click here |
| ***\*If an IV or SC product*:** Infusion Rate - *at start*: | 00 |  *mL/hr*Infusion Rate - *at time of event*: | 00 | *mL/hr* |
| **Event onset date:** | dd/mm/yyyy | **Time:** | HH:MM |
| **Description of Adverse Reaction or Event** *(signs, symptoms, relevant test results* ***–*** *add separate page if necessary)* |
| Click here to enter text. |
| Obs | Date/time | RR | SpO2 % | RA? | O2 (L or %) | HR | BP | Temp |
| Baseline | dd/mm/yyy HH:MM | 00 | 00 | [ ]  Yes  | 00 L/% | 00 | Sys / Dia | 00.0 |
| At event | dd/mm/yyy HH:MM | 00 | 00 | [ ]  Yes  | 00 L/% | 00 | Sys / Dia | 00.0 |
| **Treatment of Adverse Reaction or Event** *(include any medicines given, with dose/route)* |
| Click here to enter text. |
| **Action taken:** | [ ]  None | [ ]  Infusion discontinued  | [ ]  Infusion interrupted  | [ ]  Infusion rate reduced  | [ ]  Unknown |
| **Other Medicines in Use** *(include premeds, anaesthetic agents and OTC products* – *add a separate page if necessary)* |
| **Medicine** | **Daily Dose (with units)** | **Route** | **Date Started** *or* **>3 months** | **Date Stopped *o****r* **Ongoing** | **Indication(s) for Use**  |
| Click here | 000 | XX | dd/mm/yyyy | dd/mm/yyyy | Click here |
| Click here | 000 | XX | dd/mm/yyyy | dd/mm/yyyy | Click here |
| Click here | 000 | XX | dd/mm/yyyy | dd/mm/yyyy | Click here |
| Click here | 000 | XX | dd/mm/yyyy | dd/mm/yyyy | Click here |
| Click here | 000 | XX | dd/mm/yyyy | dd/mm/yyyy | Click here |
| Click here | 000 | XX | dd/mm/yyyy | dd/mm/yyyy | Click here |

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| **Assessment of severity and imputability** |
| **After stopping suspected blood product, did the reaction abate?** [ ]  Yes [ ]  No [ ]  Not applicable |
| **If the blood product was re-introduced, did the reaction reoccur?** [ ]  Yes [ ]  No [ ]  Not applicable |
| **Has the suspected blood product been tolerated in the past?** [ ]  Yes [ ]  No [ ]  Not applicable |
| **Has other IVIg medication been tolerated in the past?** [ ]  Yes [ ]  No [ ]  Not applicable |
| **Was the event serious?** *(Significant injury or harm or treatment needed to preserve life)*[ ]  **No:** *Did the patient require hospitalisation or was hospitalisation prolonged?* [ ]  Yes [ ]  No [ ]  N/A [ ]  **Yes:** *Please tick at least one of the following outcome boxes:*[ ]  Resulted in death[ ]  Life-threatening[ ]  Resulted in disability or incapacity [ ]  Associated with congenital anomaly or birth defect[ ]  Required hospitalisation [ ]  Hospitalisation was prolonged[ ]  Suspected infusion of an infectious agent[ ]  Medically significant – *details:* Click here to enter text. | **Imputability Assessment:** *Likely correlation to blood product* [ ]  Certain [ ]  Likely [ ]  Possible [ ]  Unlikely [ ]  Unrelated [ ]  Unassessable |
| **Case Outcome:** *(at time of reporting)*  |
| [ ]  **Recovered:**  | Recovery date | dd/mm/yyyy | Time | HH:MM | [ ]  **Recovering**  |
| [ ]  **Not yet recovered**  | [ ]  **Permanently disabled** | [ ]  **Outcome unknown**  |
| [ ]  **Recovered with sequelae** *(specify):*  | Click here |
| [ ]  **Fatal**:  | Death date | dd/mm/yyyy | Autopsy date: | dd/mm/yyyy | *or*  [ ]  not undertaken |
| Cause of death | Click here |
| **Report type:** *(please tick all that apply)* |
| [ ]  Product used for a MedSafe-registered indication [ ]  Medication error[ ]  Under-dose[ ]  Lactation occurring[ ]  Occupational exposure  | [ ]  Section 29 Medicine[ ]  Incorrect product transfused [ ]  Quality defect in product[ ]  Lack of effect [ ]  Misuse | [ ]  Off-label use [ ]  Overdose[ ]  Pregnancy[ ]  Unexpected therapeutic benefit |
| **Adverse Event Reported by: (essential)** | **Treating Specialist/GP/Midwife: (essential)**  |
| Name: | Click here | Name: | Click here |
| Role: | Click here | Role: | Click here |
| Organisation: | Click here | Organisation: | Click here |
| EMAIL: | Click here | EMAIL: | Click here |
| **DATE**: | dd/mm/yyyy |  |  |
| If the reporter is the patient, has consent been given by the patient to contact the treating specialist to follow-up the adverse event? [ ]  Yes [ ]  No | **Registrar name and email:** *(if relevant)* |
| Click here |
| **If the adverse event is serious, please contact a Transfusion Medicine Specialist via your local Blood Bank.** |

**Please send this completed form AS SOON AS POSSIBLE to your Blood Bank/TNS or forward it to:** **Adverse.Reaction@nzblood.co.nz**