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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 | | | | | | | | |
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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**](mailto:Adverse.Reaction@nzblood.co.nz)