Date Received		Risk Level		Imputability		Signature	
HV No						QC No: (if applicable)		Recall No (if applicable)	

HV form 1: National Haemovigilance Office

Initial Report Form

1. Patient Details

Hospital:		Unique Incident Number		Gender *Please* ✓	Male □ Female □	Age *Please **USE** appropriate denominator*	Years Months Days	

2. List unit numbers of components/products IMPLICATED

	Unit Numbers
Red Cells	
Platelets Apheresis	
Platelets Pooled	
Solvent detergent (SD) Plasma	
FFP	
Cryoprecipitate	
Medicinal Products (*please specify*)	

3. Other Details

Date of transfusion	___/___/_____	Time Transfusion Started	___:___ am/pm	Date reaction noticed	___/___/_____	Time reaction noticed	___:___ am/pm
Date error discovered	___/___/_____	Time error discovered	___:___ am/pm	Date error occurred	___/___/_____	Time error occurred	___:___ am/pm
Fluid balance recorded? *Please* ✓		Yes □ No □			Volume transfused	_____mls	

4. Baseline observations prior to reaction

Temp:		Pulse:		BP:	

5. What is the patient's primary diagnosis? *Please* ✓	Surgical □ Medical □ Obstetric □	Oncology/Haematology □ Other □
Details:		

6. What was the reason for the transfusion? *Please* ✓	Low Platelet Count / Platelet Function Deficit □ Haemorrhage □ Anaemia □ Plasma Coagulation Disorder □	Ante Natal □ Post Natal □ Other □
Details:		

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Recall No (if applicable)							

7. Previous medical or surgical history?

History *Please* ✓		Details
Surgical	□	
Medical	□	
Obstetric	□	
Oncology/Haematology	□	
Other	□	

8. Transfusion History

Year	Month	Outcome	Details

9. Pre-transfusion haematology values

If red cells transfused state pre-transfusion Hb		Pre-transfusion PT	
If platelets transfused state pre-transfusion platelet count		Pre-transfusion APTT	
If plasma transfused state pre-transfusion INR		Was Vitamin K administered? *Please* ✓	Yes □ No □

10. Summary of Error/Omission

11. Was the transfusion an emergency? *Please* ✓	Yes □ No □ Unknown □ N/A □	**12. Interval between commencing transfusion and onset of symptoms**	Minutes Hours Days Weeks Months	
Further interval information if necessary:				

13. Symptoms present in the case of a reaction (*tick and or record details in relevant boxes*)

Symptom	✓	Details	Symptom	✓	Details
Temperature Rise			Fever		
Urticaria			Chills/Rigors		
Hypotension			Back pain		
Hypertension			Sub-sternal discomfort		
Tachycardia			GI symptoms, including cramps		

Date Received		Risk Level		Imputability		Signature	
HV No							
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Symptom	✓	Details	Symptom	✓	Details
Bradycardia			Falling haemoglobin		
Dyspnoea			Falling urinary output		
Stridor / Wheeze			Haemoglobinuria		
Cyanosis			Pain along infusion site		
Falling O2 saturation			Restlessness/anxiety		
Rising pCO2			Other		
Chest X ray changes					

14. Has your supplying IBTS Quality Assurance Department been informed?	Yes □ No □	If **Yes**, person informed	
		If **Yes**, date Informed	_____/_____/_____

15. HAS this report has been submitted to the NHO from another reporting establishment e.g. Irish Blood Transfusion Service or hospital?	**Yes** □	**No** □
If Yes, state name of reporting establishment		
If Yes, what is unique incident number from that reporting establishment?		

Nature of Incident

Serious Adverse Event	✓	Details
Blood to wrong patient (if no reaction)		
Incorrect ABO and Rh D group transfused (if no reaction)		
Incorrect ABO group transfused (if no reaction)		
Incorrect Rh D group transfused (if no reaction)		
Transfusion of other incorrect antigen / incompatible antigen RCC (if no reaction)		
Incorrect component/product transfused		
Inappropriate transfusion		
Failure to give an irradiated component		
Failure to give CMV negative component		
Transfusion of an incorrectly labelled component		
Transfusion of expired component		
Transfusion of incorrectly stored component		
Transfusion of incorrectly distributed component		
Failure to administer product (Anti D)		
Delay in giving product (Anti D)		
Other		

	System Failure	Design	□	Materials	□
		Culture	□	Construction	□
		Management Priorities	□	Training Not Provided	□
		Other	□	External	□
		Policies/Procedures	□		

Post Event Review		
19. What corrective action was taken as a result of this error?		
20. Describe the preventative action proposed to minimise the risk of error recurrence		
21. Has the case been reviewed by the hospital transfusion committee? Please ✓	Yes □ No □	Hospital does not have Transfusion Committee □ No but will be in the future □
22. Has this case been reviewed by the consultant haematologist	Yes □ No □	Details:

Information to complete this form was obtained from Please ✓

Patient's Case Notes □	Patient's Hospital Consultant □	Nurse/Midwife Looking After the Patient □
Medical/Lab Scientist □	Haemovigilance Officer □	Consultant Haematologist / Pathologist □
Doctor □	Other □	

Please give details:	

Report completed by:

Name:

_____ **Title**: _____

Working Address: _____

Email Address: _____

Telephone: _____ **Date**: _____/_____/_____

The National Haemovigilance Office,
National Blood Centre, James's Street, Dublin 8Tel: 01 432 2741/432 2825 Fax: 01 432 2731

Date Received		Risk Level		Imputability		Signature	
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Serious Adverse Reaction	✓	Details
Immunological haemolysis due to ABO incompatibility		
Immunological haemolysis due to other allo-antibody (Acute < 24 hrs.)		
Immunological haemolysis due to other allo-antibody (Delayed > 24 hrs.)		
Non-immunological haemolysis		
Anaphylaxis/hypersensitivity		
Febrile Non Haemolytic Transfusion Reaction		
Transfusion Associated Circulatory Overload		
Transfusion Associated Dyspnoea		
Hypotensive Transfusion Reaction		
Previously un-reported complication of transfusion (PUCT)		
Other –Unclassified SAR		
Pre-deposit autologous donation		
Post transfusion purpura		
Graft versus host disease		
Transfusion-transmitted bacterial infection*		
Transfusion related acute lung injury (TRALI) *		
Transfusion transmitted viral infection (HBV) *		
Transfusion transmitted viral infection (HCV) *		
Transfusion transmitted viral infection (HIV-1/2) *		
Transfusion transmitted viral infection – Other (*please specify*) *		
Transfusion transmitted parasitical – Malaria *		
Transfusion transmitted parasitical – Other (*please specify*) *		
Transfusion-transmitted prion infection*		

Imputability of serious adverse reaction				
Excluded - 0	□	Unlikely - 0	□	Possible - 1 □
Likely/Probable – 2	□	Certain – 3	□	Not Assessable – NA □

*** NB**

If **suspected** please contact **Quality Control Laboratory** or Medical Scientist on duty at your blood supply centre:

Cork: 021 480 7400 **Dublin: 01 432 2800**

For specific information on completing the form please consult The Haemovigilance Handbook: Requirements for Reporting Serious Adverse Reactions and Events to the National Haemovigilance Office (Current Version).

Report made by:

Name:_____ **Title**:_____

Working Address:_____

Telephone:_____ **Date**: _____/_____/_____

Consultant Haematologist/Pathologist or patient's Primary Consultant must review each initial report prior to it being sent to:

The National Haemovigilance Office
At The National Blood Centre, James's Street, Dublin 8
Tel: 01 432 2741/ 01 432 2825
Fax: 01 432 2933