



**National Institute of Biologicals**  
 Ministry of Health & Family Welfare, Govt. of India  
 (National Coordinating Center)  
**HAEMOVIGILANCE PROGRAMME OF INDIA**



**Transfusion Reaction Reporting Form (TRRF) For Blood & Blood Components & Plasma Products**

\* Mandatory Field

**(A) Patient Information**

Hospital Code No.: \_\_\_\_\_  
 Patient Initials\*: \_\_\_\_\_ Gender\*: \_\_\_\_\_ Blood Group\*: \_\_\_\_\_  
 Hospital Admission No. \*: \_\_\_\_\_ Age/Date of Birth\*: \_\_\_\_\_ Yrs \_\_\_\_\_ Month \_\_\_\_\_ Days \_\_\_\_\_ Hrs \_\_\_\_\_ Mins  
 Primary Diagnosis\*: \_\_\_\_\_  
 Medical History: \_\_\_\_\_

**(B) Transfusion Reaction Details\***

Was the patient under anaesthesia during transfusion: Yes/No if Yes type : GA/Spinal/LA \_\_\_\_\_  
 Pre-transfusion Vitals: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ RR: \_\_\_\_\_ SPO2: \_\_\_\_\_  
 Vitals at the time of reaction: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ RR: \_\_\_\_\_ SPO2: \_\_\_\_\_  
 Please tick mark the relevant signs and symptoms listed below

Generalised	Pain	Respiratory	Renal	Circulatory
<input type="checkbox"/> Fever	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Dyspnoea	<input type="checkbox"/> Haematuria	<input type="checkbox"/> Tachycardia
<input type="checkbox"/> Chills	<input type="checkbox"/> Abdominal	<input type="checkbox"/> Wheeze	<input type="checkbox"/> Haemoglobinuria	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Rigors	<input type="checkbox"/> Back/Flank Pain	<input type="checkbox"/> Cough	<input type="checkbox"/> Oliguria	<input type="checkbox"/> Hypotension
<input type="checkbox"/> Nausea	<input type="checkbox"/> Infusion Site Pain	<input type="checkbox"/> Hypoxemia	<input type="checkbox"/> Other _____	<input type="checkbox"/> Raised JVP
<input type="checkbox"/> Urticaria	<input type="checkbox"/> Other _____	<input type="checkbox"/> _____		<input type="checkbox"/> Arrhythmias
<input type="checkbox"/> Flushing		<input type="checkbox"/> Bilateral Infiltrates on		<input type="checkbox"/> Other _____
<input type="checkbox"/> Restlessness		<input type="checkbox"/> Chest X-ray		
<input type="checkbox"/> Vomiting		<input type="checkbox"/> Other _____		

Any Other (Specify) : \_\_\_\_\_

**(C) Transfusion Product(s) Details\***

Select*	Select Component	Select Indication	Date & Time of Issue of Blood Component	Date & Time of onset Transfusion	Unit Id (Transfused)	Blood Group	Volume Transfused (ml)	Expiry date of Blood Component	Manufacturer of Blood Bag	Batch / Lot No. of the Blood Bag	1st time/ repeat Transfusion
<input type="checkbox"/>	Whole blood										<input type="checkbox"/> 1st Time        <input type="checkbox"/> Repeat 1 to 10        <input type="checkbox"/> Repeat > 10
<input type="checkbox"/>	Packed Red blood cells (PRBC)										
<input type="checkbox"/>	Buffy coat depleted PRBC										
<input type="checkbox"/>	Leucofiltered PRBC										
<input type="checkbox"/>	Random Donor platelets/ pooled										
<input type="checkbox"/>	Apheresis Platelets										
<input type="checkbox"/>	Fresh Frozen Plasma										
<input type="checkbox"/>	Cryoprecipitate										
<input type="checkbox"/>	Any Other										

**Add New Plasma Product**

Select	Plasma Product	Indication	Date of Administration	Manufacturer	Expiry Date of the Plasma Product	Batch No. / Lot No.	1st Time / Repeat
							<input type="checkbox"/> 1st Time <input type="checkbox"/> Repeat 1 to 10 <input type="checkbox"/> Repeat > 10

(D) Investigations				
<input type="checkbox"/>	Clerical Checks	Specify Error Found if any: _____		
	Investigation	Pre-transfusion sample	Post-transfusion sample	
*	<input type="checkbox"/> Repeat Blood Grouping	O+ /A+ /B+ /AB+ /O- /A- /B- /AB-	O+ /A+ /B+ /AB+ /O- /A- /B- /AB-	
*	<input type="checkbox"/> Repeat Crossmatch	<input type="checkbox"/> Compatible <input type="checkbox"/> InCompatible <input type="checkbox"/> Not Done	<input type="checkbox"/> Compatible <input type="checkbox"/> InCompatible <input type="checkbox"/> Not Done	
*	<input type="checkbox"/> Repeat Antibody screen	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Done	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Done	
	<input type="checkbox"/> Antibody Identification			
*	<input type="checkbox"/> Direct antiglobulin test	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Done	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Done	
	<input type="checkbox"/> Hemoglobin			
	<input type="checkbox"/> Plasma Hemoglobin			
	<input type="checkbox"/> Urine hemoglobin			
	<input type="checkbox"/> Bilirubin (Total/conjugated)			
	<input type="checkbox"/> Platelet count			
	<input type="checkbox"/> PT/INR			
*	<input type="checkbox"/> Blood culture of Blood Bag	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Done	Specify Organism if positive _____	
*	<input type="checkbox"/> Blood culture of Patient	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Done	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Done	
	<input type="checkbox"/> Chest X-ray of the patient in case of suspected TRALI	Specify Organism if positive _____	Specify Organism if positive _____	
In case of Non-immune hemolysis (which of the following was the case?)				
<input type="checkbox"/>	Hemolysis due to freezing of PRBC Units			
<input type="checkbox"/>	Hemolysis due to inappropriate warming of PRBC Units			
<input type="checkbox"/>	Hemolysis due to infusion of any other fluid through same BT set.			Specify Fluid: _____
<input type="checkbox"/>	Mechanical damage			
In Case of ABO Mismatch (which of the following was the case?)				
<input type="checkbox"/>	Wrong Blood in tube			
<input type="checkbox"/>	Grouping error			
<input type="checkbox"/>	Labelling error			
<input type="checkbox"/>	Wrong unit transfused			
(E) Nature of Adverse Reaction(s)*				
Select	Reaction	Date & Time of Onset of Reaction	Date & Time of Recovery	Outcome
<input type="checkbox"/>	Febrile Non Haemolytic Reactions (FNHTR) 1° C rise in temperature <input type="checkbox"/> 2° C rise in temperature <input type="checkbox"/> Only Chills & Rigors <input type="checkbox"/>			<input type="checkbox"/> 1. Death following the Adverse Reaction(s)
<input type="checkbox"/>	Allergic reaction			<input type="checkbox"/> 2. Recovered
<input type="checkbox"/>	Anaphylaxis			
<input type="checkbox"/>	Immunological Haemolysis due to ABO Incompatibility			<input type="checkbox"/> 3. Recovered with Sequelae
<input type="checkbox"/>	Immunological Haemolysis due to other Allo-Antibodies			
<input type="checkbox"/>	Non Immunological Haemolysis			<input type="checkbox"/> 4. Unknown
<input type="checkbox"/>	Hypotensive Transfusion Reaction			
<input type="checkbox"/>	Transfusion Related Acute Lung Injury (TRALI)			
	Definite <input type="checkbox"/>			
	Possible <input type="checkbox"/>			
<input type="checkbox"/>	Transfusion Associated Dyspnoea (TAD)			
<input type="checkbox"/>	Transfusion Associated Circulatory Overload (TACO)			
<input type="checkbox"/>	Transfusion Transmitted Bacterial Infection			
<input type="checkbox"/>	Transfusion Transmitted Parasitic Infection (Malaria)			
<input type="checkbox"/>	Post Transfusion Purpura			
<input type="checkbox"/>	Transfusion Associated Graft versus Host Disease (TAGvHD)			
<input type="checkbox"/>	Other Reaction (s)	<input type="text"/>		
	<input type="button" value="Add New"/>	<input type="text"/>		
		<input type="text"/>		
(F) Imputability Assessment*				
S. No.	Reaction Term	Transfusion Product/ Component	*Imputability Assessment (Please mention from the below list)	
*Imputability: 1. Definite (Certain), 2. Probable (Likely), 3. Possible, 4. Unlikely (Doubtful), 5. Excluded, 6. Not Assessed				
Monthly Denominator Reporting Form *				
Hospital Code :		Month/Year:		
Blood Component		No.of Units Issued		
1) Fresh Frozen Plasma				
2) Whole Blood				
3) Packed Red Blood Cells (PRBC)				
4) Buffy Coat Depleted PRBC				
5) Leucofiltered PRBC				
6) Random Donor Platelets/ Pooled				
7) Apheresis Platelets				
8) Cryoprecipitate				
9) Any Other _____				