

BLOOD SERIOUS ADVERSE REACTION (SAR) REPORT FORM

ALL CONSUMER/PATIENT AND REPORTER INFORMATION WILL REMAIN CONFIDENTIAL

Please complete as much information as possible. Do not be put off reporting if some details are not known.

REPORT IDENTIFICATION NUMBER OF REPORTING ESTABLISHMENT: _____

RECIPIENT DETAILS (Please tick or record details accordingly)

INITIALS _____ SEX MALE FEMALE AGE (at time of SAR) _____ WEIGHT (in kg, if known) _____
ETHNICITY _____ AREA _____

TYPE OF BLOOD/BLOOD COMPONENTS (Please tick accordingly)

Batch number of blood/blood component _____

<input type="checkbox"/> Whole blood	
<input type="checkbox"/> Red Blood Cells	
<input type="checkbox"/> Platelets	
<input type="checkbox"/> Plasma	
<input type="checkbox"/> Albumin	
<input type="checkbox"/> Immunoglobulin	
<input type="checkbox"/> Other (please specify)	

DETAILS OF SERIOUS ADVERSE REACTION (SAR)

Date of Transfusion (DD/MM/YYYY): _____ / _____ / _____	Time of Transfusion: _____ a.m. / p.m.		
Date of SAR (DD/MM/YYYY): _____ / _____ / _____	Time of SAR: _____ a.m. / p.m.		
Amount transfused: _____ ml	<input type="checkbox"/> <1/4 <input type="checkbox"/> <1/2 <input type="checkbox"/> <3/4 <input type="checkbox"/> >3/4 (please tick accordingly)		
Type of SAR (please tick accordingly):	Imputability Level*	Type of SAR (please tick accordingly):	Imputability Level*
<input type="checkbox"/> Immunological haemolysis due to ABO incompatibility		<input type="checkbox"/> Transfusion-transmitted viral infection (HIV-1/2)	
<input type="checkbox"/> Immunological haemolysis due to other all-antibody		<input type="checkbox"/> Transfusion-transmitted viral infection, Other (please specify)	
<input type="checkbox"/> Non-immunological haemolysis		<input type="checkbox"/> Transfusion-transmitted parasitological infection (Malaria)	
<input type="checkbox"/> Post-transfusion bacterial infection		<input type="checkbox"/> Transfusion-transmitted parasitological infection, Other (please specify)	
<input type="checkbox"/> Transfusion-related acute lung injury		<input type="checkbox"/> Graft versus host disease	
<input type="checkbox"/> Transfusion-transmitted viral infection (HBV)		<input type="checkbox"/> Other SAR(s) (please specify)	
<input type="checkbox"/> Transfusion-transmitted viral infection (HCV)			

REPORTING ESTABLISHMENT

Type (please circle): hospital blood bank, hospital, hospital, clinic, manufacturer, bio-medical research institution
Name: _____
Address: _____
Telephone/Mobile: _____
E-mail address: _____

Signature _____ Date of Report _____

An electronic version of the SAR report form can be downloaded from: www.health.gov.mt/mru

SUPPLY OF SAR REPORT FORM IS REQUIRED

* Please mark NA, 0, 1, 2, 3** accordingly

** Refer to Blood Serious Adverse Reactions (SARs) Imputability Level Guidance Sheet for determination of the imputability level.