Clear Fields

Report of Suspected TRALI

LifeSouth Community Blood Centers

For Internal Use Only
Case File Number:

Form Completed by (Name, Job Title):		Date Completed:
Phone #:	Facility:	
Patient Name:		Patient ID #:

Date and time of onset of symptoms: _____/_____/_____ at _____ : _____ ☐am ☐pm

Describe clinical features (underlying medical conditions, presentation, treatment):

Date and time of CXR prior to reaction: _____/_____/_____ at _____ : _____ ☐am ☐pm

Interpretation:

Date and time of first post-reaction CXR: _____/_____/_____ at _____ : _____ ☐am ☐pm

Interpretation:

Date and time of the most recent CXR: _____/_____/_____ at _____ : _____ ☐am ☐pm

Interpretation:

FAX TO (888) 286-0179 • CONFIRM FAX RECEIVED AT (888) 795-2707
AFTER NORMAL BUSINESS HOURS (9AM TO 5PM ET, M-F) FAX TO (352) 334-1029 • CONFIRM FAX RECEIVED AT (352) 334-1028