

Collect data from arrival at hospital up to 24 hours post-randomisation (please refer to the calculated 24hr date on the Pre-Hospital 1 form).

Trial ID number (needs to match ID recorded in pre-hospital form): R ____

Participant Initials (if only two initials are available, please record as "A-B"): ____

Age (years): ____

Day 1 (24hrs post randomisation) date: 20 ____ / ____ / ____ (yyyy/mm/dd)

(please refer to the calculated 24hr date on the pre-hospital 1 form)

Day 1 (24hrs post randomisation) Time: ____ : ____ (24 hr time)

(please refer to the calculated 24hr time on the pre-hospital 1 form)

Participant Status at 6hrs post randomisation: (please refer to the calculated 6hr date on the pre-hospital 1 form)

Alive ☐ Dead ☐

Participant Status at 24hrs post randomisation: (please refer to the calculated 24hr date on the pre-hospital 1 form)

Alive ☐ Dead ☐

If participant has died, please complete the Exit Form

TRANSFUSION PRODUCTS ADMINISTERED (from arrival at hospital to 24hrs)

RED BLOOD CELLS (RBCs): NO / YES

If yes, specify : ____ Units / mls (delete as appropriate)

PLATELETS: NO / YES

If yes, specify : ____ Units / mls (delete as appropriate)

FRESH FROZEN PLASMA: NO / YES

If yes, specify : ____ Units / mls (delete as appropriate)

CRYOPRECIPITATE: NO / YES

If yes, specify : ____ Units / mls (delete as appropriate)

OCTAPLAS: NO / YES

If yes, specify : ____ Units / mls (delete as appropriate)

OTHER: NO / YES

If yes, specify : _____

If yes, specify : ____ Units / mls (delete as appropriate)

SWiFT Trial Day 1 (24hrs post randomisation) Report Form



SWiFT

Blood and Transplant

OTHER IN-HOSPITAL TREATMENT (including Haemostatic agents)

Cell salvage: NO / YES

If yes, how much : _____ mls

Tranexamic acid: NO / YES

If yes, dosage administered : _____ g

Fibrinogen Concentrate: NO / YES

If yes, dosage administered : _____ g

Crystalloid administration: NO / YES

If yes, volume administered : _____ ml

Colloid administration: NO / YES

If yes, volume administered : _____ ml

Calcium administration: NO / YES

If yes, please specify:

Calcium Gluconate

☐

Volume: _____ mls of 10%

Calcium Chloride

☐

Volume: _____ mls of 10%

Recombinant Factor VIIa: NO / YES

If yes, dosage administered : _____ mg

Prothrombin Complex concentrate: NO / YES

If yes, dosage administered : _____ IU