

ARRIVAL ON SCENE

Site Country: UK **Attending AAS team:** _____

Date of arrival (yyyy/mm/dd) 20 ____ / ____ / ____ **Arrival time :** ____ : ____ (24 hr time)

MRN Number (as recorded on AAS card): _____

ELIGIBILITY (should be assessed prior to opening trial box)

Did the patient suffer a traumatic injury? **NO / YES** → If yes, injury type: **BLUNT / PENETRATING**

Was patient attended by a participating AAS clinical team? **NO / YES**

Does patient require pre-hospital blood transfusion to treat major traumatic haemorrhage? **NO/ YES**

Was there intravenous or intraosseous access : **NO / YES**

Knowledge that patient will object to blood transfusion for any reasons : **NO / YES**

Was blood administered on-scene, prior to arrival of participating AAS? **NO / YES**

Is the patient eligible for the trial? **NO / YES**

IF ELIGIBLE, PATIENT IS ENROLLED INTO THE TRIAL UNDER EMERGENCY WAIVER OF CONSENT

Was the participant in traumatic cardiac arrest on arrival of the medical team? **NO / YES**

Approximate participant age: _____ years Estimated weight: _____ kgs

Full name & role (in capitals) of person confirming eligibility :

TRIAL BOX UNSEALED (RANDOMISATION)

TRIAL ID NUMBER (from box): R ____ _

Date trial box opened (yyyy/mm/dd) 20 ____ / ____ / ____ Time opened: ____ : ____ (24 hr time)

Box contents: ☐ INTERVENTION (Whole Blood) / ☐ STANDARD CARE (RBCs and plasma)

TRANSFUSION PRODUCTS ADMINISTERED (on scene, at interim hospital, or during journey)

Were transfusion products given? **NO / YES**

If **no** transfusion products given, please state why:

Transfusion start time: ____ : ____ (24 hr time) **Transfusion end time:** ____ : ____ (24 hr time)

Were the contents of the SWiFT box the first blood products given to the patient at the scene (i.e. no blood was administered on scene prior to the AAS arriving)? **NO / YES**

WHOLE BLOOD: transfused from trial box? **NO / YES**

Transfusion start date: 20 ____ / ____ / ____ (yyyy/mm/dd)

Administration route: IV / IO Specify Measurement: _____ **Units / mls?** (delete as appropriate)

Donation 1: G _____

Donation 2: G _____

SWiFT Trial Pre-hospital Report Form



TRANSFUSION PRODUCTS ADMINISTERED cont.

RED BLOOD CELLS (RBCs): transfused from trial box?

NO / YES

Transfusion start date: 20 ____ / ____ / ____ (yyyy/mm/dd)

Administration route: IV / IO Specify Measurement: ____ Units / mls? (delete as appropriate)

Donation 1: G _____

Donation 2: G _____

FRESH FROZEN PLASMA (FFP): transfused from the trial box? NO / YES

Transfusion start date: 20 ____ / ____ / ____ (yyyy/mm/dd)

Administration route: IV / IO Specify Measurement: ____ Units / mls? (delete as appropriate)

Donation 1: G _____

Donation 2: G _____

LYOPHILISED PLASMA: transfused as Standard Care? NO / YES

Transfusion start date: 20 ____ / ____ / ____ (yyyy/mm/dd)

Administration route: IV / IO Specify Measurement: ____ Units / mls? (delete as appropriate)

Lyophilised plasma series 1: _____

Lyophilised plasma series 2: _____

ADDITIONAL PRODUCTS TRANSFUSED (from outside trial box/ as standard of care)? NO / YES

RBCs: ____ units / mls FFP: ____ units / mls Lyophilised plasma: ____ units / mls

VITAL SIGNS

	1. FIRST RECORDED	2. AT DECISION TO TRANSFUSE
Heart rate (bpm):		
Respiratory rate (/min):		
Glasgow Coma Scale:		
Blood Pressure detected?	NO / YES	NO / YES
⇒ If no, please specify	☐ Radial pulse palpable ☐ Central pulse palpable ☐ No central pulse palpable	☐ Radial pulse palpable ☐ Central pulse palpable ☐ No central pulse palpable
Systolic blood pressure (mmHg):		
Diastolic blood pressure (mmHg):		
Capillary Oxygen Saturation (SpO2)%:		

OTHER PRE-HOSPITAL TREATMENT:

Was the participant anaesthetised pre-hospital?	N / Y	
Did the participant receive tranexamic acid?	N / Y	Dosage: _____ g
Did the participant receive Fibrinogen concentrate?	N / Y	Dosage: _____ g
Did the participant receive Crystalloid?	N / Y	Volume: _____ ml
Did the participant receive Colloid?	N / Y	Volume: _____ ml
Did the participant receive calcium gluconate 10%?	N / Y	Volume: _____ mls
Did the participant receive calcium chloride 10%?	N / Y	Volume: _____ mls

JOURNEY FROM SCENE:

Date AAS left scene: (yyyy/mm/dd) 20 ____ / ____ / ____ Time : ____ : ____ (24 hr time)

Was an interim hospital stop required? (i.e. at another hospital, before arriving at definitive hospital) **NO / YES**

If yes, name of hospital: _____

Reason for stop: _____

Were other products transfused*: **NO / YES**

*(IF YES, PLEASE ENSURE THAT DETAILS ARE ADDED ON PAGE 2: "ADDITIONAL PRODUCTS TRANSFUSED")

Receiving hospital: _____

Was randomised treatment still being given upon arrival at hospital? **NO / YES**

PATIENT OUTCOME:

Did the participant suffer cardiac arrest prior to arrival at hospital? **NO / YES**

Did the participant die:

1. on scene? **NO / YES**

2. on route to the hospital? **NO / YES**

If participant died on scene / route to hospital, please complete the following:

Date of death: 20 ____ / ____ / ____ (yyyy/mm/dd) Time of Death ____ : ____ (24 hr time)

Primary cause of death: ☐ uncontrolled bleeding ☐ Multi-organ failure

☐ Myocardial infarction ☐ Multiple Injury ☐ Stroke ☐ Traumatic Brain Injury

☐ Pulmonary embolism ☐ Sepsis ☐ Other: _____

IF THE PARTICIPANT DIED ON SCENE / EN ROUTE, RECEIVING HOSPITAL TO COMPLETE EXIT FORM

PLEASE EMAIL A COPY OF THIS FORM TO THE RELEVANT RECEIVING HOSPITAL USING THE CONTACT DETAILS YOU HAVE BEEN PROVIDED WITH. DO NOT EMAIL THIS FORM TO THE SWIFT TRIAL TEAM AT NHSBT CTU