

AAS teams to complete for all patients who receive blood from a trial box & email to receiving hospital to enter

ARRIVAL ON SCENE:

Site Country: UK Attending AAS team: _____
 Arrival date (yyyy/mm/dd) & time of AAS team: 20 ____ / ____ / ____ : ____ (24 hr time)
 Were AAS 1st on scene? **NO / YES**

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 unsealed (yyyy/mm/dd) 20 ____ / ____ / ____ Time unsealed: ____ : ____ (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 indicate why: _____

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

Transfusion start date and time: 20 ____ / ____ / ____ (yyyy/mm/dd) ____ : ____ (24 hr time)

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

Donation 1: G _____ Date donor bled: 20 ____ / ____ / ____ (yyyy/mm/dd)

Donation 2: G _____ Date donor bled: 20 ____ / ____ / ____ (yyyy/mm/dd)

RED BLOOD CELLS (RBCs): transfused from trial box? **NO / YES**

Transfusion start date and time: 20 ____ / ____ / ____ (yyyy/mm/dd) ____ : ____ (24 hr time)

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

Donation 1: G _____ Date donor bled: 20 ____ / ____ / ____ (yyyy/mm/dd)

Donation 2: G _____ Date donor bled: 20 ____ / ____ / ____ (yyyy/mm/dd)

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

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

Transfusion start date and time: 20 ____ / ____ / ____ (yyyy/mm/dd) ____ : ____ (24 hr time)

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

Donation 1: G _____ Date donor bled: 20 ____ / ____ / ____ (yyyy/mm/dd)

Donation 2: G _____ Date donor bled: 20 ____ / ____ / ____ (yyyy/mm/dd)

LYOPHILISED PLASMA: transfused as Standard Care? **NO / YES**

Transfusion start date and time: 20 ____ / ____ / ____ (yyyy/mm/dd) ____ : ____ (24 hr time)

Administration route: IO / IA 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 & time AAS left scene: 20 ____ / ____ / ____ (yyyy/mm/dd) ____ : ____ (24 hr time)

Was an interim hospital stop required? (i.e. at another hospital, before arriving at definitive hospital) N / Y

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: _____

Patient Initials: ____

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.