

AAS teams to complete for all patients who receive blood from a trial box

ARRIVAL ON SCENE: **MRN Number** (as recorded on AAS card): _____
 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: 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)

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: 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)

LYOPHILISED PLASMA: transfused as Standard Care? **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)

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: 2 0 ____ / ____ / ____ (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: 2 0 ____ / ____ / ____ (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