

Pre-Hospital



Complete for all patients who receive blood products from a 'trial box'

ARRIVAL ON-SCENE

Site Country

☐ UK

Attending AAS team

- ☐ Air Ambulance Kent Surrey Sussex
- ☐ Dorset and Somerset Air Ambulance
- ☐ East Anglian Air Ambulance
- ☐ Essex and Herts Air Ambulance
- ☐ Hampshire and Isle of Wight Air Ambulance
- ☐ Great North Air Ambulance
- ☐ Great Western Air Ambulance
- ☐ London Air Ambulance
- ☐ Magpas Air Ambulance
- ☐ North West Air Ambulance
- ☐ Thames Valley Air Ambulance
- ☐ Other

If 'Other' Attending AAS team, please specify

Arrival date of AAS team
yyyy-mm-dd

Arrival time of AAS team
Please enter in 24hr format hh:mm

ELIGIBILITY (Should be assessed prior to opening trial box)**Participant Inclusion Criteria**

Did the patient (of any age) suffer a traumatic injury?

- ☐ No ☐ Yes

Was the patient attended by a participating Air Ambulance Service clinical team?

- ☐ No ☐ Yes

Does the patient require pre-hospital blood transfusion to treat major traumatic haemorrhage?

- ☐ No ☐ Yes

Participant Exclusion Criteria

Was there intravenous or intraosseous access?

- ☐ No ☐ Yes

Knowledge that patient will object to being given blood transfusions for any reasons.

- ☐ No ☐ Yes

Was blood already administered on-scene, prior to arrival of the 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

If yes, please specify the type of traumatic injury the patient suffered

☐

Blunt

☐

Penetrating

Was the patient in traumatic cardiac arrest (no pulse, no signs of life) on arrival of the medical team?

☐

No

☐

Yes

Approximate Patient Age

Years

Estimated Weight

Kg

Full name of person confirming eligibility

Role of person confirming Eligibility

TRIAL BOX UNSEALED (RANDOMISATION)

Date that trial box was unsealed (date of randomisation)

yyyy-mm-dd

Time that trial box was unsealed (time of randomisation)

Please enter in 24hr format hh:mm

Trial ID number (on trial box) (RXXXX) 	
Please select the Box Contents Intervention (whole blood) Standard care (red blood cells and plasma)	
Transfusion PRODUCTS ADMINISTERED (on scene, at interim hospital or during journey)	
Were transfusion products given? ☐ No ☐ Yes	
If NO transfusion products were given, please indicate why? 	
Whole Blood	
Was Whole Blood transfused from the trial box? ☐ No ☐ Yes	
Transfusion Start Date yyyy-mm-dd	Transfusion Start Time <i>Please enter in 24hr format hh:mm</i>
Administration Route ☐ Intravenous ☐ Intraosseous	
Please specify unit of measurement of transfusion for Paediatric ☐ Units ☐ mls	
No. of Units 	

Volume in mls	WB Donation 1 GXXXXXXXXXXXXX
WB Donation 2 GXXXXXXXXXXXXX (Please leave blank if NA)	Date donor was bled (Donor 1) yyyy-mm-dd
Date donor was bled (Donor 2) yyyy-mm-dd	
Red Blood Cells	
Were Red Blood Cells transfused from the trial box? ☐ No ☐ Yes	
Transfusion Start Date yyyy-mm-dd	Transfusion Start Time Please enter in 24hr format hh:mm
Administration Route ☐ Intravenous ☐ Intraosseous	
Please specify unit of measurement of transfusion for Paediatric ☐ Units ☐ mls	
No. of Units	
Volume in mls	RBC Donation 1 GXXXXXXXXXXXXX
RBC Donation 2 GXXXXXXXXXXXXX (Please leave blank if NA)	Date donor was bled (Donor 1) yyyy-mm-dd

Date donor was bled (Donor 2) yyyy-mm-dd	
Were additional Red Blood Cells transfused from outside the trial box? ☐ No ☐ Yes	
Please specify unit of measurement of transfusion for Paediatric ☐ Units ☐ mls	
No. of Units	
Volume in mls	
Fresh Frozen Plasma	
Was Fresh Frozen Plasma transfused from the trial box? ☐ No ☐ Yes	
Transfusion Start Date yyyy-mm-dd	Transfusion Start Time Please enter in 24hr format hh:mm
Administration Route ☐ Intravenous ☐ Intraosseous 	
Please specify unit of measurement of transfusion for Paediatric ☐ Units ☐ mls	
No. of Units	
Volume in mls	FFP Donation 1 GXXXXXXXXXXXXX

FFP Donation 2 GXXXXXXXXXXXXX (Please leave blank if NA)	Date donor was bled (Donor 1) yyyy-mm-dd
Date donor was bled (Donor 2) yyyy-mm-dd	
Was additional Fresh Frozen Plasma transfused from outside the trial box? ☐ No ☐ Yes	
Please specify unit of measurement of transfusion for Paediatric ☐ Units ☐ mls	No. of Units
Volume in mls	
Lyophilised Plasma	
Was Lyophilised Plasma transfused as Standard Care? ☐ No ☐ Yes	
Transfusion Start Date yyyy-mm-dd	Transfusion Start Time Please enter in 24hr format hh:mm
Administration Route ☐ Intravenous ☐ Intraosseous	
Please specify unit of measurement of transfusion for Paediatric ☐ Units ☐ mls	
No. of Units	

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Volume in mls	Lyophilised Plasma Series 1 XXXXXXXXXXXXXXXXXXXX (17 digits)
Lyophilised Plasma Series 2 XXXXXXXXXXXXXXXXXXXX (17 digits) (Please leave blank if NA)	
Was additional Lyophilised Plasma transfused as Standard Care? No Yes	
Please specify unit of measurement of transfusion for Paediatric Units mls	No. of Units
Volume in mls	

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VTAL SIGNS (FIRST RECORDED)

Heart Rate
bpm

Respiratory Rate
/min

Glasgow Coma Scale

Was the participant's blood pressure detected?

☐

No

☐

Yes

If NO, please specify

☐

Radial pulse palpable

☐

Central pulse palpable

☐

No central pulse palpable

Systolic blood pressure
mmHg

Diastolic blood pressure
mmHg

Capillary Oxygen Saturation (SpO2)
%

VTAL SIGNS AT DECISION TO TRANSFUSE

Heart Rate <i>bpm</i>	Respiratory Rate <i>/min</i>
Glasgow Coma Scale	Was the participant's blood pressure detected? ☐ No ☐ Yes
If NO, please specify ☐ Radial pulse palpable ☐ Central pulse palpable ☐ No central pulse palpable	
Systolic blood pressure <i>mmHg</i>	Diastolic blood pressure <i>mmHg</i>
Capillary Oxygen Saturation (SpO2) <i>%</i>	
OTHER PRE-HOSPITAL TREATMENT	
Was the participant anaesthetised Pre-Hospital? ☐ No ☐ Yes	
Did the participant receive Tranexamic acid? ☐ No ☐ Yes	If YES, dosage of Tranexamic acid administered <i>g</i>
Did the participant receive Fibrinogen concentrate? ☐ No ☐ Yes	If YES, dosage of Fibrinogen concentrate administered <i>g</i>
Did the participant receive Crystalloid administration? ☐ No ☐ Yes	If YES, volume of Crystalloid administration <i>ml</i>
Did the participant receive Colloid administration? ☐ No ☐ Yes	If YES, volume of Colloid administration <i>ml</i>
Did the participant receive Calcium administration? ☐ No ☐ Yes	If YES, did the participant receive ☐ Calcium Gluconate ☐ Calcium Chloride

Volume of Calcium Gluconate administration <i>mls of 10% solution</i>	Volume of Calcium Chloride administration <i>mls of 10% solution</i>
JOURNEY FROM SCENE	
Date AAS left scene yyyy-mm-dd	Time AAS left scene <i>Please enter in 24hr format hh:mm</i>
Was a stop at an interim hospital required? (i.e. at another hospital, before arriving at definitive hospital) ☐ No ☐ Yes	
If YES, name the hospital at which the interim stop was made 	
Reason for interim stop? 	
Were other products transfused? ☐ No ☐ Yes	
If YES, please ensure details are recorded in the relevant ADDITIONAL transfused sections in the previous Pre-Hospital 1 form <i>e.g. RBC should be recorded in 'Were additional Red Blood Cells transfused from outside the trial box?'</i>	

Receiving Hospital

- ☐ Addenbrooke's Hospital Cambridge
- ☐ Aintree University Hospital Liverpool
- ☐ Alder Hey Children's Hospital Liverpool
- ☐ Bristol Royal Infirmary
- ☐ Bristol Royal Hospital for Children
- ☐ Dorset County Hospital
- ☐ East Surrey Hospital
- ☐ Jame Cook University Hospital Middlesbrough
- ☐ James Radcliffe Hospital Oxford
- ☐ King's College Hospital London
- ☐ Manchester Royal Infirmary
- ☐ Peterborough City Hospital
- ☐ Princess Alexandra Hospital Harlow
- ☐ Royal London Hospital
- ☐ Royal Manchester Children's Hospital
- ☐ Royal Preston Hospital Lancashire
- ☐ Royal Sussex County Hospital Brighton
- ☐ Royal Victoria Infirmary Newcastle
- ☐ Salford Royal Hospital
- ☐ Southampton General Hospital
- ☐ Southmead Hospital Bristol
- ☐ St George's Hospital London
- ☐ St Mary's Hospital London
- ☐ University Hospital of Coventry and Warwickshire
- ☐ Other

If 'Other' receiving hospital, please specify:

Was randomised treatment still being given upon arrival at receiving hospital?

- ☐ No ☐ Yes

PATIENT OUTCOME

Did the participant suffer cardiac arrest prior to arrival at receiving hospital?

- ☐ No ☐ Yes

Died on-scene? ☐ No ☐ Yes
Died en-route to hospital? ☐ No ☐ Yes
IF PARTICIPANT DIED ON SCENE OR ON WAY TO RECEIVING HOSPITAL, PLEASE COMPLETE EXIT FORM.