OMB No. 0920-0666
Exp. Date: xx-xx-xxxx
www.cdc.gov/nhsn

Hemovigilance Module
Adverse Reaction

*Required for saving

*Facility ID#: _____ | NHSN Adverse Reaction #: _____

Patient Information

*Patient ID: _____ *Gender: ☐ M ☐ F ☐ Other *Date of Birth: __ __/__ __/__ __ __ __

Social Security #: _____ Secondary ID: _____ Medicare #: _____

Last Name: _____ First Name: _____ Middle Name: _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

*Blood Group: ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ Type and crossmatch not done

*Primary underlying reason for transfusion: ☐ Coagulopathy ☐ Genetic Disorder ☐ Hematology Disorder ☐ Hemolysis ☐ Internal Bleeding ☐ Malignancy ☐ Medical ☐ Surgery ☐ Unknown ☐ Other (specify) _____

Reaction Details

*Date reaction occurred: __ __/__ __/__ __ __ __

*Time reaction occurred: __ __:__ __ (HH:MM) ☐ Time unknown

*Facility location where patient was transfused: _____

*Is this reaction associated with an incident? ☐ Yes ☐ No If Yes, Incident #: _____

*Signs and symptoms, laboratory: (check all that apply)

Cardiovascular:
- ☐ Blood pressure decrease
- ☐ Shock

Hemolysis/Hemorrhage
- ☐ Disseminated intravascular coagulation
- ☐ Hemoglobinemia
- ☐ Positive antibody screen

Generalized:
- ☐ Chills/rigors
- ☐ Fever

Cutaneous:
- ☐ Edema
- ☐ Flushing
- ☐ Jaundice
- ☐ Other rash
- ☐ Pruritus (itching)
- ☐ Urticaria (hives)

Renal:
- ☐ Hematuria
- ☐ Hemoglobinuria
- ☐ Oliguria

Pain:
- ☐ Abdominal pain
- ☐ Back pain
- ☐ Flank pain
- ☐ Infusion site pain

Respiratory:
- ☐ Bilateral infiltrates on chest x-ray
- ☐ Bronchospasm
- ☐ Cough
- ☐ Hypoxemia
- ☐ Shortness of breath

☐ Other: (specify) _____

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency

Investigation Results (Use case definition criteria in protocol.)

*Adverse reaction: (check one)

- ☐ Allergic reaction, including anaphylaxis
- ☐ Acute hemolytic transfusion reaction (AHTR)
  - ☐ Immune Antibody: _____ ☐ Non-immune (specify) _____
- ☐ Delayed hemolytic transfusion reaction (DHTR)
  - ☐ Immune Antibody: _____ ☐ Non-immune (specify) _____
- ☐ Delayed serologic transfusion reaction (DSTR) Antibody: _____
- ☐ Febrile non-hemolytic transfusion reaction (FNHTR)
- ☐ Hypotensive transfusion reaction
- ☐ Infection

  Was a test to detect a specific pathogen performed on the recipient post-transfusion?

  ☐ Yes ☐ No If Yes, positive or reactive results? ☐ Yes ☐ No

  Org1 _____ Org2 _____ Org3 _____

  Was a test to detect a specific pathogen performed on the donor post-donation?

  ☐ Yes ☐ No If Yes, positive or reactive results? ☐ Yes ☐ No

  Org1 _____ Org2 _____ Org3 _____

  Was a test to detect a specific pathogen performed on the unit post-transfusion? (i.e., culture, serology, NAT)

  ☐ Yes ☐ No If Yes, positive or reactive results? ☐ Yes ☐ No

  Org1 _____ Org2 _____ Org3 _____
- ☐ Post transfusion purpura (PTP)
- ☐ Transfusion associated circulatory overload (TACO)
- ☐ Transfusion associated dyspnea (TAD)
- ☐ Transfusion associated graft vs. host disease (TA-GVHD)

  Did patient receive non-irradiated blood product(s) in the two months preceding the reaction? ☐ Yes ☐ No
- ☐ Transfusion related acute lung injury (TRALI)

  Antibody studies performed: (optional)

	Not Done	Negative	Test result positive		
			Cognate or cross reacting antigen present	No cognate or cross reacting antigen present	Not tested for cognate antigen
Donor or unit HLA specificity	☐	☐	☐	☐	☐
Donor or unit HNA specificity	☐	☐	☐	☐	☐
Recipient HLA specificity	☐	☐	☐	☐	☐
Recipient HNA specificity	☐	☐	☐	☐	☐

- ☐ Unknown pathophysiology
- ☐ Other (specify) _____

*Case definition criteria: ☐ Definitive ☐ Probable ☐ Possible ☐ N/A

*Severity: ☐ Non-severe ☐ Severe ☐ Life-threatening ☐ Death ☐ Not determined

*Imputability: ☐ Definite ☐ Probable ☐ Possible ☐ Doubtful ☐ Ruled Out ☐ Not determined

Outcome

*Outcome: ☐ Death+ ☐ Major or long-term sequelae ☐ Minor or no sequelae ☐ Not determined

Date of Death: __ __/__ __/__ __ __ __ **+Deaths attributable to transfusion must be reported to FDA.**

^If recipient died, relationship of transfusion to death:

☐ Definite ☐ Probable ☐ Possible ☐ Doubtful ☐ Ruled Out ☐ Not determined

Component Details (Use worksheet on page 4 for additional units.)

*Was a particular unit implicated in the adverse reaction? ☐ Yes ☐ No ☐ N/A

*Transfusion Date/Time MM/DD/YYYY HH:MM	*Component code (check system used)	*# of units	^Unit number *Required for TRALI, GVHD, Infection*	Unit collection Date/Time MM/DD/YYYY HH:MM	*Unit expiration Date/Time MM/DD/YYYY HH:MM	*Blood group of unit	IMPLICATED
^IMPLICATED UNIT							
___/___/_____ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __ __ __ __	1	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ __ __:__ __	___/___/_____ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	Y
___/___/_____ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ __ __:__ __	___/___/_____ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/_____ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ __ __:__ __	___/___/_____ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N

Custom Fields

Label		Label	
_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments

_____

_____

Component Details (continued)

*Transfusion Date/Time MM/DD/YYYY HH:MM	*Component code (check system used)	*# of units	^Unit number *Required for TRALI, GVHD, Infection*	Unit collection Date/Time MM/DD/YYYY HH:MM	*Unit expiration Date/Time MM/DD/YYYY HH:MM	*Blood group of unit	IMPLICATED
___/___/______ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/______ __ __:__ __	___/___/______ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/______ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/______ __ __:__ __	___/___/______ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/______ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/______ __ __:__ __	___/___/______ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/______ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/______ __ __:__ __	___/___/______ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/______ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/______ __ __:__ __	___/___/______ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/______ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/______ __ __:__ __	___/___/______ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/______ __ __:__ __	☐ ISBT-128 ☐ Codabar __ __ __ __ __		__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/______ __ __:__ __	___/___/______ __ __:__ __	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐	N

					N/A	