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Hemovigilance Module
Adverse Reaction
Delayed Serologic Transfusion 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+ ☐ Blood type not done

Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.)

(part 1) List the patient's admitting diagnosis. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____

(part 2) List the patient's underlying indication for transfusion. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____

(part 3) List the patient's comorbid conditions at the time of the transfusion related to the adverse reaction. *(Use ICD-10 Diagnostic codes/descriptions)* ☐ UNKNOWN ☐ NONE

Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____

Continued >>

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)).

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Delayed Serologic Transfusion Reaction

Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.)

(part 4) List the patient's relevant medical procedure including past procedures and procedures to be performed during the current hospital or outpatient stay. *(Use ICD-10 Procedure codes/descriptions)*

☐ UNKNOWN
☐ NONE

Code: ______________ Description: ____

Code: ______________ Description: ____

Code: ______________ Description: ____

(part 5) Additional Information ____

____

____

Transfusion History (Use worksheet on page 4 for additional transfusion history.)

Has the patient received a previous transfusion? ☐ YES ☐ NO ☐ UNKNOWN

***If yes, provide information about the transfusion event. If not, skip to Reaction Details section.*

Blood Product: ☐ WB ☐ RBC ☐ Platelet ☐ Plasma ☐ Cryoprecipitate ☐ Granulocyte

Date of Transfusion: ____/____/_____ ☐ UNKNOWN

Did the patient experience a transfusion adverse reaction? ☐ YES ☐ NO

If yes, provide information about the transfusion adverse reaction.

Type of transfusion adverse reaction: ☐ Allergic ☐ AHTR ☐ DHTR ☐ DSTR ☐ FNHTR ☐ HTR ☐ TTI ☐ PTP ☐ TACO ☐ TAD ☐ TA-GVHD ☐ TRALI ☐ UNKNOWN ☐ OTHER Specify ______________________________

Reaction Details

*Date reaction occurred: ____/____/____ *Time reaction occurred: __ __:__ __ ☐ Time unknown

*Facility location where patient was transfused: ________________________________

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

After recognition of the transfusion reaction, was the current transfusion:

☐ Continued ☐ Stopped and restarted ☐ Stopped indefinitely

Investigation Results

☐ **Delayed serologic transfusion reaction (DSTR)**

Antibody(ies): ____

Case Definition

Check all that apply:

☐ Absence of clinical signs of hemolysis
☐ Positive direct antiglobulin test (DAT)
☐ Demonstration of new, clinically-significant antibodies against red blood cells
☐ Positive antibody screen with newly identified RBC alloantibody
☐ None of the above

Continued >>

Delayed Serologic Transfusion Reaction

Investigation Results (continued)

Other signs and symptoms: (check all that apply)

Generalized:	☐ Chills/rigors	☐ Fever	☐ Nausea/vomiting	
Cardiovascular:	☐ Blood pressure decrease	☐ Shock		
Cutaneous:	☐ Edema ☐ Other rash	☐ Flushing ☐ Pruritus (itching)	☐ Jaundice ☐ Urticaria (hives)	
Hemolysis/Hemorrhage:	☐ Disseminated intravascular coagulation	☐ Hemoglobinemia		
Pain:	☐ Abdominal pain	☐ Back pain	☐ Flank pain	☐ Infusion site pain
Renal:	☐ Hematuria	☐ Hemoglobinuria	☐ Oliguria	
Respiratory:	☐ Bilateral infiltrates on chest x-ray ☐ Hypoxemia	☐ Bronchospasm ☐ Shortness of breath	☐ Cough	

☐ Other: (specify) ____________________

Severity

Did the patient receive or experience any of the following? *(Response definitions listed in protocol)*

☐ Symptomatic treatment only ☐ Hospitalization, inlcuding prolonged hospitalization
☐ Life-threatening reaction ☐ Disability and/or incapacitation
☐ Congenital anomaly or birth defect(s) of the fetus ☐ Death
☐ Other medically important conditions ☐ Unknown or not stated

Imputability

Which best describes the relationship between the transfusion and the reaction?

☐ Transfusion performed by your facility is the only possible cause for seroconversion.
☐ The patient has other exposures (e.g. transfusion by another facility or pregnancy) that could explain seroconversion, but transfusion by your facility is the most likely cause.
☐ The patient was transfused by your facility, but other exposures are present that most likely explain seroconversion.
☐ Evidence is clearly in favor of a cause other than the transfusion, but transfusion cannot be excluded.
☐ There is conclusive evidence beyond reasonable doubt of a cause other than the transfusion.
☐ The relationship between the adverse reaction and the transfusion is unknown or not stated.

Did the transfusion occur at your facility? ☐ YES ☐ NO

When was the new alloantibody identified?

☐ Occurred between 24 hours and 28 days after cessation of transfusion
☐ Occurred less than 24 hours after cessation of transfusion OR greater than 28 days after cessation of transfusion
☐ No new antibody was identified

Additional Information ____________________

Continued >>

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Delayed Serologic Transfusion Reaction

Patient Treatment

*Did the patient receive treatment for the transfusion reaction? ☐ YES ☐ NO

If yes, select treatment(s):

☐ **Medication** *(Select the type of medication)*

☐ Antipyretics ☐ Antihistamines ☐ Inotropes/Vasopressors ☐ Bronchodilator ☐ Diuretics

☐ Intravenous Immunoglobulin ☐ Intravenous steroids ☐ Corticosteroids ☐ Antibiotics

☐ Antithymocyte globulin ☐ Cyclosporin ☐ H1 receptor blockers ☐ Other

☐ **Volume resuscitation** (Intravenous colloids or crystalloids)

☐ **Respiratory support** *(Select the type of support)*

☐ Mechanical ventilation ☐ Noninvasive ventilation ☐ Oxygen

☐ **Renal replacement therapy** *(Select the type of therapy)*

☐ Hemodialysis ☐ Peritoneal ☐ Continuous Veno-Venous Hemofiltration

☐ **Phlebotomy**

☐ **Other** Specify: ____

Outcome

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

Date of Death: ____/____/_____

^If recipient died, relationship of transfusion to death:

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

Cause of death: ____

Was an autopsy performed? ☐ Yes ☐ No

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Delayed Serologic Transfusion Reaction

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

*Was a particular unit implicated in (i.e., responsible for) the adverse reaction? ☐ Yes ☐ No ☐ N/A

*Transfusion **Start** and **End** Date/Time	*Component code (check system used)	*Amount transfused at reaction onset	*Unit number	*Unit expiration Date/Time	*Blood group of unit	Implicated Unit?
^IMPLICATED UNIT						
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	Y
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N

Custom Fields

Label		Label	
_______________	______/______/________	_______________	______/______/________
_______________	__________________	_______________	__________________
_______________	__________________	_______________	__________________
_______________	__________________	_______________	__________________

Comments

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Hemovigilance Module
Additional Worksheet

Patient Medical History

(part 1) List the patient's admitting diagnosis. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____

(part 2) List the patient's underlying indication for transfusion. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____

(part 3) List the patient's comorbid conditions at the time of the transfusion related to the adverse reaction. *(Use ICD-10 Diagnostic codes/descriptions)*

☐ UNKNOWN
☐ NONE

Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____

(part 4) List the patient's relevant medical procedure including past procedures and procedures to be performed during the current hospital or outpatient stay. *(Use ICD-10 Procedure codes/descriptions)*

☐ UNKNOWN
☐ NONE

Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____
Code: ______________ Description: ____

(part 5) Additional Information ____
____
____
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Additional Worksheet

Transfusion History

Has the patient received a previous transfusion? ☐ YES ☐ NO

***If yes, provide information about the transfusion event. If not, skip to Reaction Details section.*

Blood Product: ☐ WB ☐ RBC ☐ Platelet ☐ Plasma ☐ Cryoprecipitate ☐ Granulocyte

Date of Transfusion: ____/____/_____ ☐ UNKNOWN

Did the patient experience a transfusion adverse reaction? ☐ YES ☐ NO

If yes, provide information about the transfusion adverse reaction.

Type of transfusion adverse reaction: ☐ Allergic ☐ AHTR ☐ DHTR ☐ DSTR ☐ FNHTR ☐ HTR ☐ TTI ☐ PTP ☐ TACO ☐ TAD ☐ TA-GVHD ☐ TRALI ☐ UNKNOWN ☐ OTHER Specify ____

Has the patient received a previous transfusion? ☐ YES ☐ NO

***If yes, provide information about the transfusion event. If not, skip to Reaction Details section.*

Blood Product: ☐ WB ☐ RBC ☐ Platelet ☐ Plasma ☐ Cryoprecipitate ☐ Granulocyte

Date of Transfusion: ____/____/_____ ☐ UNKNOWN

Did the patient experience a transfusion adverse reaction? ☐ YES ☐ NO

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Has the patient received a previous transfusion? ☐ YES ☐ NO

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Blood Product: ☐ WB ☐ RBC ☐ Platelet ☐ Plasma ☐ Cryoprecipitate ☐ Granulocyte

Date of Transfusion: ____/____/_____ ☐ UNKNOWN

Did the patient experience a transfusion adverse reaction? ☐ YES ☐ NO

If yes, provide information about the transfusion adverse reaction.

Type of transfusion adverse reaction: ☐ Allergic ☐ AHTR ☐ DHTR ☐ DSTR ☐ FNHTR ☐ HTR ☐ TTI ☐ PTP ☐ TACO ☐ TAD ☐ TA-GVHD ☐ TRALI ☐ UNKNOWN ☐ OTHER Specify ____

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Additional Worksheet

Component Details

*Was a particular unit implicated in (i.e., responsible for) the adverse reaction? ☐ Yes ☐ No ☐ N/A

*Transfusion **Start** and **End** Date/Time	*Component code (check system used)	*Amount transfused at reaction onset	*Unit number	*Unit expiration Date/Time	*Blood group of unit	Implicated Unit?
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____	☐ ISBT-128	☐ Entire unit	__ __ __ __ __	___/___/_____	☐ ☐ A+ ☐ B-	N

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___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ Codabar ___ ___ ___ ___ ___ _________________	☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __	 _____ : _____	A- ☐ B+ ☐ O-	 ☐ AB- ☐ O+	 ☐ AB+ ☐ N/A	