



Hemovigilance Module Adverse Reaction Transfusion Associated Dyspnea

*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 >>

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Transfusion Associated Dyspnea

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

Transfusion associated dyspnea (TAD)

Case Definition

Check all that apply:

- Acute respiratory distress occurring within 24 hours of cessation of transfusion.
- Allergic reaction, TACO, and TRALI definitions are not applicable.
- None of the above

Continued >>

Transfusion Associated Dyspnea

Investigation Results (continued)

Other signs and symptoms: (check all that apply)

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

Severity

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

- | | |
|---|---|
| <input type="checkbox"/> Symptomatic treatment only | <input type="checkbox"/> Hospitalization, including prolonged hospitalization |
| <input type="checkbox"/> Life-threatening reaction | <input type="checkbox"/> Disability and/or incapacitation |
| <input type="checkbox"/> Congenital anomaly or birth defect(s) of the fetus | <input type="checkbox"/> Death |
| <input type="checkbox"/> Other medically important conditions | <input type="checkbox"/> Unknown or not stated |

Imputability

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

- Patient has no other conditions that could explain symptoms.
- There are other potential causes that could explain symptoms, but transfusion is the most likely cause.
- Other present causes are most likely, but transfusion cannot be ruled out.
- 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

Additional Information _____

Continued >>

Transfusion Associated Dyspnea

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

Continued >>

Transfusion Associated Dyspnea

Component Details (Use worksheet on page 4 for additional units.)							
*Was a particular unit implicated in (i.e., responsible for) the adverse reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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							
____/____/____ ____:____:____ ____/____/____ ____:____:____	<input type="checkbox"/> ISBT-128 <input type="checkbox"/> Codabar	<input type="checkbox"/> Entire unit <input type="checkbox"/> Partial unit mL	____-____-____ ____-____-____ ____-____-____ ____-____-____	____/____/____ ____:____:____ ____/____/____ ____:____:____	<input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B- <input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+ <input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A		Y
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Comments	
_____ _____ _____ _____	

Hemovigilance Module Additional Worksheet

Patient Medical History

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

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(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)*

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(part 5) Additional Information _____

Hemovigilance Module 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

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Type of transfusion adverse reaction: Allergic AHTR DHTR DSTTR FNHTR
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Hemovigilance Module Additional Worksheet

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