



## Hemovigilance Module Adverse Reaction Transfusion Associated Circulatory Overload

\*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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CDC 57.318 (Front) Rev 1, v8.8

## Transfusion Associated Circulatory Overload

### 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 circulatory overload (TACO)**

#### \*Case Definition

Check all that occurred within 6 hours of cessation of transfusion (new onset or exacerbation):

- Acute respiratory distress (dyspnea, orthopnea, cough)
- Elevated brain natriuretic peptide (BNP)
- Elevated central venous pressure (CVP)
- Evidence of left heart failure
- Evidence of positive fluid balance
- Radiographic evidence of pulmonary edema
- None of the above

Continued >>

## Transfusion Associated Circulatory Overload

Investigation Results (continued)	
Other signs and symptoms: <u>(check all that apply)</u>	
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) _____	
<b>*Severity</b>	
Did the patient receive or experience any of the following? <i>(Response definitions listed in protocol)</i>	
<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
<b>*Imputability</b>	
Which best describes the relationship between the transfusion and the reaction?	
<input type="checkbox"/> No other explanations for circulatory overload are possible.	
<input type="checkbox"/> Transfusion is a likely contributor to circulatory overload	
<input type="checkbox"/> The patient has a history of a pre-existing condition(s) that most likely explains circulatory overload.	
<input type="checkbox"/> Evidence is clearly in favor of a cause other than the transfusion, but transfusion cannot be excluded.	
<input type="checkbox"/> There is conclusive evidence beyond reasonable doubt of a cause other than the transfusion.	
<input type="checkbox"/> The relationship between the adverse reaction and the transfusion is unknown or not stated.	
Did the transfusion occur at your facility? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does the patient have a history of cardiac insufficiency?	
<input type="checkbox"/> Yes, the patient has a history of cardiac insufficiency that could explain the circulatory overload, but transfusion is just as likely to have caused the circulatory overload.	
<input type="checkbox"/> Yes, the patient has a history of pre-existing cardiac insufficiency that most likely explains circulatory overload.	
<input type="checkbox"/> No, the patient does not have a history of cardiac insufficiency.	
<i>Continued &gt;&gt;</i>	

## Transfusion Associated Circulatory Overload

Investigation Results (continued)		
Did the patient received other fluids in addition to the transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Designations for case definition, severity, and imputability will be automatically assigned in the NHSN application based on responses in the corresponding investigation results section above.		
Do you agree with the case definition designation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please indicate your designation _____		
Do you agree with the severity designation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please indicate your designation _____		
Do you agree with the imputability designation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please indicate your designation _____		
Additional Information _____		

Patient Treatment
*Did the patient receive treatment for the transfusion reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN If yes, select treatment(s): <input type="checkbox"/> <b>Medication</b> (Select the type of medication) <input type="checkbox"/> Antipyretics <input type="checkbox"/> Antihistamines <input type="checkbox"/> Inotropes/Vasopressors <input type="checkbox"/> Bronchodilator <input type="checkbox"/> Diuretics <input type="checkbox"/> Intravenous Immunoglobulin <input type="checkbox"/> Intravenous steroids <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Antithymocyte globulin <input type="checkbox"/> Cyclosporin <input type="checkbox"/> H1 receptor blockers <input type="checkbox"/> Other  <input type="checkbox"/> <b>Volume resuscitation</b> (Intravenous colloids or crystalloids)  <input type="checkbox"/> <b>Respiratory support</b> (Select the type of support) <input type="checkbox"/> Mechanical ventilation <input type="checkbox"/> Noninvasive ventilation <input type="checkbox"/> Oxygen  <input type="checkbox"/> <b>Renal replacement therapy</b> (Select the type of therapy) <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Continuous Veno-Venous Hemofiltration  <input type="checkbox"/> <b>Phlebotomy</b> <input type="checkbox"/> <b>Other</b> Specify: _____

Outcome
*Outcome: <input type="checkbox"/> Death <input type="checkbox"/> Major or long-term sequelae <input type="checkbox"/> Minor or no sequelae <input type="checkbox"/> 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 Circulatory Overload

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
____/____/____ ____:____:____ ____/____/____ ____:____:____	<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		N
____/____/____ ____:____:____ ____/____/____ ____:____:____	<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		N

Custom Fields	
Label	Label
_____ _____ _____	_____ _____ _____
Comments	
_____ _____ _____ _____	

## 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Hemovigilance Module Additional Worksheet

Transfusion History
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></b></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></b></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></b></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>



## Hemovigilance Module Additional Worksheet

Component Details								
*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?	
____/____/____ ____:____ ____/____/____ ____:	<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"/> B + <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<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"/> B + <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<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"/> B + <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<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"/> B + <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<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"/> B + <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<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"/> B + <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<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"/> B + <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<input type="checkbox"/> ISBT-128	<input type="checkbox"/> Entire unit	____-____-____ ____-____-____	____/____/____	<input type="checkbox"/> A- <input type="checkbox"/> A+	<input type="checkbox"/> B- <input type="checkbox"/> B-	N	



____ : ____	<input type="checkbox"/> Codabar	unit	____						
____ / ____ / ____	_____	<input type="checkbox"/> Partial unit	_____						
____ : ____		_____ mL	_____						
						A-			
						<input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	
						+	AB-	AB+	
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						O-	<input type="checkbox"/> O+	N/A	