



## Hemovigilance Module Adverse Reaction Unknown 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 >>*

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## Unknown 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

\*  **Unknown**  
 Diagnosis of case: \_\_\_\_\_

List tests relevant to reaction investigation:

Test name: \_\_\_\_\_ Testing date: \_\_\_\_\_ Test result: \_\_\_\_\_  
 Test name: \_\_\_\_\_ Testing date: \_\_\_\_\_ Test result: \_\_\_\_\_

*Continued >>*

## Unknown Transfusion Reaction

### 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		

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?

- Conclusive evidence exists that the adverse reaction can be attributed to the transfusion.
- Evidence is clearly in favor of attributing the adverse reaction to the transfusion.
- Evidence is indeterminate for attributing the adverse reaction to the transfusion or an alternate cause.
- 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

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?     YES     NO

Please indicate your designation \_\_\_\_\_

Do you agree with the severity designation?     YES     NO

Please indicate your designation \_\_\_\_\_

Do you agree with the imputability designation?     YES     NO

Please indicate your designation \_\_\_\_\_

Additional Information \_\_\_\_\_

*Continued >>*

## Unknown Transfusion Reaction

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"/> Intravenous Immunoglobulin	<input type="checkbox"/> Inotropes/Vasopressors
<input type="checkbox"/> Antithymocyte globulin	<input type="checkbox"/> Cyclosporin
<input type="checkbox"/> Intravenous steroids	<input type="checkbox"/> Bronchodilator
<input type="checkbox"/> H1 receptor blockers	<input type="checkbox"/> Diuretics
<input type="checkbox"/> Corticosteroids	<input type="checkbox"/> Antibiotics
<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:	
<input type="checkbox"/> Definite	<input type="checkbox"/> Probable
<input type="checkbox"/> Possible	<input type="checkbox"/> Doubtful
<input type="checkbox"/> Ruled Out	<input type="checkbox"/> Not determined
Cause of death:	_____
Was an autopsy performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Continued &gt;&gt;</i>	

## Unknown 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? <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: _____
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**(part 2)** List the patient's underlying indication for transfusion. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
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**(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: _____
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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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 NONE

Code: _____	Description: _____
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Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____

**(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

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