



Hemovigilance Module Adverse Reaction Delayed Hemolytic 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: _____

Continued >>

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Public reporting burden of this collection of information is estimated to average 20 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 may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333 ATTN: PRA (0920-0666).
CDC 57.309 Rev.1 v8.8

Delayed Hemolytic Transfusion Reaction

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

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: _____

(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 (Only answer questions listed under the selected reaction type.)

* **Delayed hemolytic transfusion reaction (DHTR)**

Immune Antibody: _____ Non-immune (specify) _____

*Case Definition

Check all that occurred between **24 hours and 28 days** after cessation of transfusion:

- Positive direct antiglobulin test (DAT)
- Newly-identified red blood cell alloantibody in recipient serum
- Positive elution test with alloantibody present on the transfused red blood cells
- Inadequate rise of post-transfusion hemoglobin level or rapid fall in hemoglobin back to pre-transfusion levels
- Otherwise unexplained appearance of spherocytes
- None of the above

Continued >>

Delayed Hemolytic Transfusion Reaction

Investigation Results (continued)	
Check all that apply: <input type="checkbox"/> Incomplete laboratory evidence <input type="checkbox"/> DHTR is suspected, but reported symptoms, test results, and/or available information are not sufficient	
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
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? (<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	
*Imputability Which best describes the relationship between the transfusion and the reaction? <input type="checkbox"/> No other explanation for symptoms or newly-identified antibody is present. <input type="checkbox"/> An alternate explanation for symptoms or newly-identified antibody is present, but transfusion is the most likely cause. <input type="checkbox"/> Other explanations for symptoms or newly-identified antibody are more likely, but transfusion cannot be ruled out. <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	
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 _____

Continued >>

Delayed Hemolytic Transfusion Reaction

Do you agree with the imputability designation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Additional Information _____		

Patient Treatment																					
<p>*Did the patient receive treatment for the transfusion reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN</p> <p>If yes, select treatment(s):</p> <p><input type="checkbox"/> Medication (Select the type of medication)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Antipyretics</td> <td><input type="checkbox"/> Antihistamines</td> <td><input type="checkbox"/> Inotropes/Vasopressors</td> <td><input type="checkbox"/> Bronchodilator</td> <td><input type="checkbox"/> Diuretics</td> </tr> <tr> <td><input type="checkbox"/> Intravenous Immunoglobulin</td> <td><input type="checkbox"/> Intravenous steroids</td> <td><input type="checkbox"/> Corticosteroids</td> <td><input type="checkbox"/> Antibiotics</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Antithymocyte globulin</td> <td><input type="checkbox"/> Cyclosporin</td> <td><input type="checkbox"/> H1 receptor blockers</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p><input type="checkbox"/> Volume resuscitation (Intravenous colloids or crystalloids)</p> <p><input type="checkbox"/> Respiratory support (Select the type of support)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Mechanical ventilation</td> <td><input type="checkbox"/> Noninvasive ventilation</td> <td><input type="checkbox"/> Oxygen</td> </tr> </table> <p><input type="checkbox"/> Renal replacement therapy (Select the type of therapy)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Hemodialysis</td> <td><input type="checkbox"/> Peritoneal</td> <td><input type="checkbox"/> Continuous Veno-Venous Hemofiltration</td> </tr> </table> <p><input type="checkbox"/> Phlebotomy</p> <p><input type="checkbox"/> Other Specify: _____</p>	<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"/> Mechanical ventilation	<input type="checkbox"/> Noninvasive ventilation	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Peritoneal	<input type="checkbox"/> Continuous Veno-Venous Hemofiltration
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<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Peritoneal	<input type="checkbox"/> Continuous Veno-Venous Hemofiltration																			

Outcome
<p>*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</p> <p>Date of Death: ___/___/___</p> <p>^*If recipient died, relationship of transfusion to death:</p> <p><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</p> <p>Cause of death: _____</p> <p>Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Delayed Hemolytic 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: _____
Code: _____	Description: _____
Code: _____	Description: _____

(part 2) & 253 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><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></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"/> DSTR <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><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></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"/> DSTR <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>
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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 # of Units	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"/> 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"/> B	<input type="checkbox"/>	<input type="checkbox"/>	
		+ <input type="checkbox"/>	AB-	AB+	
		O- <input type="checkbox"/>	<input type="checkbox"/> O+	N/A	