



Hemovigilance Module Adverse Reaction Infection

*Facility ID#:	NUICNI Advance Departing //s
	NHSN Adverse Reaction #:
Patient Info	mation
*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 Med	cal History (Use worksheet on page 4 for additional codes and descriptions.)
(part 1) Lis	t the patient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
Code:	Description:
	Description:
(part 2) List	the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
Code:	Description:
	Description:
	t the patient's comorbid conditions at the time of the transfusion related to the ction. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
	Description:
	Description:
	Continued >>
of any individual stated, and will no Sections 304, 30 Public reporting to reviewing instruction of informaless it displays collection of informal states.	infidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes of otherwise be disclosed or released without the consent of the individual, or the institution in accordance with and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)). The voluntarily provided information is estimated to average 20 minutes per response, including the time for ions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the mation. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this mation, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, 3 ATTN: PRA (0920-0666).



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)
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?
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?
After recognition of the transfusion reaction, was the current transfusion:
Continued Stopped and restarted Stopped indefinitely
Investigation Results
* Infection
*Case Definition
Was a test to detect a specific pathogen performed on the recipient post-transfusion?
If Yes, positive or reactive results? Yes No
Org1 Org2 Org3
Was a test to detect a specific pathogen performed on the donor post-donation?
If Yes, positive or reactive results? Yes No
Org1 Org2 Org3
Continued >>



Investigation Results (contin							
Was a test to detect a specifi (i.e., culture, serology, NAT)	c pathogen performed or	n the unit post-transfus	sion? Yes	☐ No			
If Yes, positive or reactive	results? Yes	No					
Org1	Org2		Org3				
Check all that apply:							
Temporally associated	unexplained clinical illne	ess consistent with infe	ction				
None of the above							
Other signs and symptoms: ((check all that apply)						
Generalized:	Chills/rigors	Fever	Nause	a/vomiting			
Cardiovascular:	Blood pressure decr	rease SI	nock				
Cutanagus	Edema	Flushing	Jaundi	ice			
Cutaneous:	Other rash	Pruritus (itchin	g) Urticar	ria (hives)			
	Disseminated intrav	ascular coagulation	Hemoglobine	emia			
Hemolysis/Hemorrhage:	Positive antibody screen						
				Infusion site			
Pain:	Abdominal pain	Back pain FI	ank pain p	ain			
Renal:	Hematuria	Hemoglobinuri	a Oliguri	a			
Respiratory:	Bilateral infiltrates on chest x-ray Bronchospasm Cough						
	Hypoxemia	Shortness of b	reath				
Other: (specify)							
							
*Severity				_			
Did the patient receive or ex		• , ,	•	ŕ			
Symptomatic treatme	nt only Hospital	lization, inlcuding prolo	nged hospitalizat	tion			
Life-threatening react	ion	Disability and/	or incapacitation				
Congenital anomaly of	or birth defect(s) of the fe	etus	Death				
Other medically impo	rtant conditions		Unknown or r	not stated			
*Imputability							
Which best describes the rela	ationship between the tra	ansfusion and the reac	tion?				
No other potential exposures to the pathogen could be identified in the recipient.							
Evidence is clearly in f	favor of a cause other tha	an transfusion, but trar	sfusion cannot b	e excluded.			
There is conclusive evidence beyond reasonable doubt of a cause other than the transfusion.							
The relationship betwe	en the adverse reaction a	and the transfusion is	unknown or not s	tated.			
				Continued >>			



Investigation Results (continued)							
Check all that apply:							
Evidence of the pathogen in the transfused component.							
Evidence of the pathogen in the donor at the time of donation.							
Evidence of the pathogen in an additional component from the same donation.							
Evidence of the pathogen in an additional recipient of a component from the same donation.							
Evidence that the identified pathogen strains are related by molecular or extended phenotypic comparison testing with statistical confidence (p<0.05).							
Evidence that the transfused component was negative for this pathogen at the time of transfusion							
Evidence that the donor was negative for this pathogen at the time of donation.							
Evidence that additional components from the same donation were negative for this pathogen.							
Evidence that the recipient was not infected with the pathogen prior to transfusion.							
Laboratory evidence that the recipient was infected with this pathogen prior to transfusion.							
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?							
Please indicate your designation							
Do you agree with the severity designation?							
Please indicate your designation							
Do you agree with the imputability designation?							
Please indicate your designation							
Additional Information							
Patient Treatment							
*Did the patient receive treatment for the transfusion reaction?							
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							
Renal replacement therapy (Select the type of therapy)							



Outcome									
Minor or no									
*Outcome:									
Date of		/							
^*If	recipient died, relation	· —	_	_			1		
	Definite Probabl	e Possib	le _	Doubtful	Ruled Out		Not	determir	ied
Cause (of death:						_		
Was an	autopsy performed?	Yes	No						
Component	Details (Use works	heet on page 4	for add	ditional unit	ts.)				
	ular unit implicated ir		ble for) the adver	se reaction?	Yes	;	No	N/A
Transfusion	*Commonant code	Amount			*I lait avairation				Implicat
Start and End Date/Time	*Component code (check system used)	transfused at reaction onset	Unit n	umber	*Unit expiration Date/Time	*Blood	l arou	p of unit	ed Unit?
^IMPLICATED		Todolon oncot	01		- Dator Fillio		. <u>g</u> . o a	p or arm	1011111
MINIFLICATED									
//	ISBT-128								
:	Codabar	Entire unit Partial unit				A-	A+	- B-	Y
1 1		mL				B+	AB-	AB+	•
						□ ₀₋	O+	⊦ ⊟ _{N/A}	
	ISBT-128			_	·			1 1 1 1 1	
		Entire unit			, ,	A-	A+	- B-	
:	Codabar	Partial unit				<u> </u>			N
//		mL				В+	AB-	AB+	
:					:	O-	Пон	⊦	
	ISBT-128								
	Codabar	Entire unit			, ,	A-	A+	- В-	
<u> </u>	Codabai	Partial unit							N
/		mL				B+	AB-	AB+	
<u> </u>				_	<u> </u>	O-	O+	+	
Custom Field	ds								
Label				Label					
		1 1					1	1	
		·	_						
-									
Comments									







Hemovigilance Module Additional Worksheet

(part 1) List the pa	ient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
Code:	Description:
Code:	Description:
Code:	
Code:	Description:
Code:	
(part 2) List the pat	ent's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
Code:	
	ient's comorbid conditions at the time of the transfusion related to the UNKNOW lse ICD-10 Diagnostic codes/descriptions)
	se ICD-10 Diagnostic codes/descriptions)
adverse reaction. (Se ICD-10 Diagnostic codes/descriptions)
adverse reaction. (C Code: Code:	Se ICD-10 Diagnostic codes/descriptions) NONE Description: Description:
adverse reaction. (UCOde: Code: Code	Se ICD-10 Diagnostic codes/descriptions)
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adverse reaction. (Code:	Description:
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adverse reaction. (Code: Code:	Description:



Hemovigilance Module Additional Worksheet

Transfusion History
Has the patient received a previous transfusion?
**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.
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Date of Transfusion:// UNKNOWN
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Has the patient received a previous transfusion?
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Date of Transfusion://UNKNOWN
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OTHER Specify



Hemovigilance Module Additional Worksheet

Component D	Details								
*Was a particula	ar unit implicated in ((i.e., responsi	ble for) the adverse read	ction?	Ye	es	No		I/A
Transfusion Start and End Date/Time	*Component code (check system used)	Amount transfused at reaction onset	Unit number	*Unit expiration Date/Tir		*Bloc	od group	o of	Implic ated Unit?
// : //	ISBT-128 Codabar	Entire unit Partial unitmL				A- B +	A+ AB- O+	B- AB+ N/A	N
	ISBT-128 Codabar	Entire unit Partial unitmL				A- B +	A+ AB- O+	B- AB+ N/A	N
:	ISBT-128 Codabar	Entire unit Partial unit mL				A- B +	A+	B- AB+	N
	ISBT-128 Codabar	Entire unit Partial unit unit mL				A- B	A+	B-	N
	ISBT-128 Codabar	Entire unit Partial unitmL		//		A- B +	A+	B-	N
	ISBT-128 Codabar	Entire unit Partial unit unitmL				A- B	A+	B-	N
/	ISBT-128	Entire					A+	B-	N

National He Safety Ne	althcare etwork				OMB No Exp. Date	m Approv . 0920-06 e: xx/xx/20 dc.gov/nh	666 Oxx
:	Codabar	unit Partial unitmL		A- B +	AB-	AB+	