



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

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 _____		

Transfusion Associated Dyspnea

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"/> Medication <i>(Select the type of medication)</i>	
<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"/> Corticosteroids
<input type="checkbox"/> H1 receptor blockers	<input type="checkbox"/> Diuretics
<input type="checkbox"/> Other	<input type="checkbox"/> Bronchodilator
<input type="checkbox"/> Volume resuscitation (Intravenous colloids or crystalloids)	
<input type="checkbox"/> Respiratory support <i>(Select the type of support)</i>	
<input type="checkbox"/> Mechanical ventilation	<input type="checkbox"/> Noninvasive ventilation
<input type="checkbox"/> Renal replacement therapy <i>(Select the type of therapy)</i>	<input type="checkbox"/> Oxygen
<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Peritoneal
<input type="checkbox"/> Phlebotomy	<input type="checkbox"/> Continuous Veno-Venous Hemofiltration
<input type="checkbox"/> Other	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 >></i>	

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	<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	<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	<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)*

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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)*

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 NONE

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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)*

UNKNOWN
 NONE

Code: _____	Description: _____
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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

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 DSTTR FNHTR
 HTR TTI PTP TACO TAD TA-GVHD TRALI UNKNOWN
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Hemovigilance Module Additional Worksheet

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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
____/____/____ ____:____ ____/____/____ ____:____	<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-			