



Hemovigilance Module Adverse Reaction Allergic 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
 Transitional ABO / Rh + Transitional ABO / Rh - Transitional ABO / Transitional Rh
 Group A/Transitional Rh Group B/Transitional Rh Group O/Transitional Rh Group AB/Transitional Rh

Patient Medical History

List the patient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions)

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

List the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions)

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

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: _____

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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).

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: _____

Additional Information _____

Transfusion History

Has the patient received a previous transfusion? YES NO UNKNOWN

Blood Product: WB RBC Platelet Plasma Cryoprecipitate Granulocyte

Date of Transfusion: ___/___/___ UNKNOWN

Was the patient's adverse reaction transfusion-related? 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

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 #: _____

Investigation Results

* Allergic reaction, including anaphylaxis

*Case Definition

Check the following that occurred during or within **4 hours** of cessation of transfusion:

Conjunctival edema Edema of lips, tongue and uvula Localized angioedema Hypotension

Erythema and edema of the periorbital area Respiratory distress; bronchospasm Urticaria

Generalized flushing Maculopapular rash Pruritus

Other signs and symptoms: (check all that apply)

Generalized: Chills/rigors Fever Nausea/vomiting

Cardiovascular: Shock

Cutaneous: Jaundice

Hemolysis/Hemorrhage: Disseminated intravascular coagulation Hemoglobinemia

Positive antibody screen

Pain: Abdominal pain Back pain Flank pain Infusion site pain

Renal: Hematuria Hemoglobinuria Oliguria

Respiratory: Bilateral infiltrates on chest x-ray Cough

Hypoxemia Shortness of breath

Other: (specify) _____

***Severity**

Did the patient receive or experience any of the following?

- | | |
|---|---|
| <input type="checkbox"/> No treatment required | <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"/> Other medically important conditions | <input type="checkbox"/> Death <input type="checkbox"/> Unknown or not stated |

***Imputability**

Which best describes the relationship between the transfusion and the reaction?

- No other evidence of environmental, drug or dietary risks.
- There are other potential causes present that could explain acute hemolysis, 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

When did the reaction occur in relation to the transfusion?

- Occurred during or within 2 hours of cessation of transfusion.
- Occurred 2 - 4 hours after cessation of transfusion.

Did the same reaction occur after the transfusion was restarted (rechallenge)? YES NO

Module-generated Designations

NOTE: 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 _____

Patient Treatment

Did the patient receive treatment for the transfusion reaction? YES NO UNKNOWN

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
 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
 Phlebotomy
 Other Specify: _____

Outcome

- *Outcome:**
 Death
 Major or long-term sequelae
 Minor or no sequelae
 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

Component Details

***Was a particular unit implicated in (i.e., responsible for) the adverse reaction?**
 Yes
 No
 N/A

Transfusion Start and End Date/Time	*Component code (check system used)	Amount transfused at reaction onset	^Unit number (Required for Infection and TRALI)	*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	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

Custom Fields

Label	Label
_____	_____
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