



## Hemovigilance Module Adverse Reaction Transfusion Associated Graft vs. Host Disease

\*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 / Transitional Rh  Transitional ABO / Rh +  Transitional ABO / Rh -  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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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  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 #: \_\_\_\_\_

### Investigation Results

\* Transfusion associated graft vs. host disease (TA-GVHD)

#### \*Case Definition

Did patient receive non-irradiated blood product(s) in the two months preceding the reaction?  Yes  No

Check all that occurred within 2 days to 6 weeks after cessation of transfusion:

- Clinical syndrome
  - Clinical syndrome characteristics:  Diarrhea  Fever  Hepatomegaly  Pancytopenia
  - Liver dysfunction (i.e., elevated ALT, AST, Alkaline phosphatase, and bilirubin)  Marrow aplasia
  - Characteristic rash: erythematous, maculopapular eruption centrally that spreads to extremities and may, in severe cases, progress to generalized erythroderma and hemorrhagic bullous formation.

#### Check all that apply:

- Characteristic histological appearance of skin or liver biopsy.
- Biopsy negative or not done.

Other signs and symptoms: (check all that apply)

Generalized:	<input type="checkbox"/> Chills/rigors	<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"/> Other rash	<input type="checkbox"/> Pruritus (itching)
	<input type="checkbox"/> Jaundice	<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"/> Bronchospasm	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath	
	<input type="checkbox"/> 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 alternative diagnoses.
- Other potential causes are present (e.g., stem cell transplantation).
- Alternative explanations are more likely (e.g., solid organ transplantation).
- 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

WBC chimerism:  WBC chimerism present  WBC chimerism not present or not done

**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
____/____/____	____/____/____
____/____/____	____/____/____

**Comments**

\_\_\_\_\_



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