Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Hemovigilance Module
Adverse Reaction
Other 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: ____

Code: ______________ Description: ____

Continued >>

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

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 57.320 (Front) Rev 1, v8.8

NHSN
National Healthcare Safety Network

Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2019
www.cdc.gov/nhsn

Other Transfusion Reaction

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

*☐ **Other**

Specify: ____

List tests relevant to reaction investigation:

Test name: _________________ Testing date: ________________ Test result: __________________

Test name: _________________ Testing date: ________________ Test result: __________________

Continued >>

Other Transfusion Reaction

Investigation Results (continued)

Other signs and symptoms: (check all that apply)

Generalized:	☐ Chills/rigors	☐ Fever	☐ Nausea/vomiting	
Cardiovascular:	☐ Blood pressure decrease	☐ Shock		
Cutaneous:	☐ Edema	☐ Flushing	☐ Jaundice	
	☐ Other rash	☐ Pruritus (itching)	☐ Urticaria (hives)	
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	☐ Bronchospasm	☐ Cough	
	☐ Hypoxemia	☐ Shortness of breath		

☐ Other: (specify) ____

*Severity

Did the patient receive or experience any of the following? *(Response definitions listed in protocol)*

- ☐ Symptomatic treatment only
- ☐ Hospitalization, inlcuding prolonged hospitalization
- ☐ Life-threatening reaction
- ☐ Disability and/or incapacitation
- ☐ Congenital anomaly or birth defect(s) of the fetus
- ☐ Death
- ☐ Other medically important conditions
- ☐ Unknown or not stated

*Imputability

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

- ☐ Conclusive evidence exists that the adverse reaction can be attributed to the transfusion.
- ☐ Evidence is clearly in favor of attributing the adverse reaction to the transfusion.
- ☐ Evidence is indeterminate for attributing the adverse reaction to the transfusion or an alternate cause.
- ☐ 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?	☐ 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 ______________________		

Additional Information ____

____

Continued >>

Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2019
www.cdc.gov/nhsn

Other Transfusion Reaction

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 ☐ 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

☐ **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

Continued >>

Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2019
www.cdc.gov/nhsn

NHSN National Healthcare Safety Network

Other 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? ☐ Yes ☐ No ☐ 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						
___/___/___ ___ ___:___ ___/___/___ ___ ___:___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	Y
___/___/___ ___ ___:___ ___/___/___ ___ ___:___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
___/___/___ ___ ___:___ ___/___/___ ___ ___:___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____ : _____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N

Custom Fields

Label		Label	
____________	____/____/_____	____________	____/____/_____
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Comments

____

____

____

____

National Healthcare Safety Network

Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2019
www.cdc.gov/nhsn

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) 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 ______________________________

NHSN National Healthcare Safety Network

Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2019
www.cdc.gov/nhsn

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 ☐ DSTR ☐ FNHTR
☐ HTR ☐ TTI ☐ PTP ☐ TACO ☐ TAD ☐ TA-GVHD ☐ TRALI ☐ UNKNOWN
☐ OTHER Specify ____

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 ☐ DSTR ☐ FNHTR
☐ HTR ☐ TTI ☐ PTP ☐ TACO ☐ TAD ☐ TA-GVHD ☐ TRALI ☐ UNKNOWN
☐ OTHER Specify ____

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 ☐ DSTR ☐ FNHTR
☐ HTR ☐ TTI ☐ PTP ☐ TACO ☐ TAD ☐ TA-GVHD ☐ TRALI ☐ UNKNOWN
☐ OTHER Specify ____

Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2019
www.cdc.gov/nhsn

NHSN National Healthcare Safety Network

Hemovigilance Module
Additional Worksheet

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	*Unit expiration Date/Time	*Blood group of unit	Implicated Unit?
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ ______:______	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ ______:______	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ ______:______	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ ______:______	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ ______:______	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____ ___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _______________	☐ Entire unit ☐ Partial unit ______mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ ______:______	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N
____/____/_____	☐ ISBT-128	☐ Entire	__ __ __ __ __	___/___/_____	☐ ☐ A+ ☐ B-	N

___ ___:___ ___ ____/____/_____ ___ ___:___ ___	☐ Codabar ___ ___ ___ ___ ___ ________________	unit ☐ Partial unit ______mL	— — — — — — — — __ __ __	______ : ______	A- ☐ B + ☐ O-	☐ AB- ☐ O+	☐ AB+ ☐ N/A	