

Hemovigilance Module Adverse Reaction Acute Hemolytic 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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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

*☐ Acute hemolytic transfusion reaction (AHTR)
☐ Immune Antibody: _____ ☐ Non-immune (specify) _____

*Case Definition

Check the following that occurred during, or within 24 hours of cessation of transfusion with **new** onset:

☐ Back/flank pain ☐ Chills/rigors ☐ Epistaxis ☐ Disseminated intravascular coagulation (DIC)
☐ Oliguria/anuria ☐ Hypotension ☐ Fever ☐ Hematuria (gross visual hemolysis)
☐ Pain and/or oozing at IV site ☐ Renal failure

Check all that apply: ☐ Decreased fibrinogen ☐ Decreased haptoglobin ☐ Elevated bilirubin
☐ Elevated LDH ☐ Hemoglobinemia ☐ Hemoglobinuria ☐ Plasma discoloration c/w hemolysis
☐ Spherocytes on blood film ☐ Positive direct antiglobulin test (DAT) for anti-IgG or anti-C3
☐ Positive elution test with alloantibody present on the transfused red blood cells
☐ Serologic testing is negative, and physical cause (e.g., thermal, osmotic, mechanical, chemical) is confirmed.
☐ Physical cause is excluded but serologic evidence is not sufficient to meet definitive criteria.
☐ Physical cause is suspected and serologic testing is negative.
☐ AHTR is suspected, but symptoms, test results, and/or information are not sufficient to confirm reaction.

Other signs and symptoms: (check all that apply)

Generalized: ☐ Nausea/vomiting
Cardiovascular: ☐ 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"/> Hemoglobinemia <input type="checkbox"/> Positive antibody screen		
Pain:	<input type="checkbox"/> Abdominal pain		
Respiratory:	<input type="checkbox"/> Bilateral infiltrates on chest x-ray	<input type="checkbox"/> Bronchospasm	<input type="checkbox"/> Cough
	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Hypoxemia	
<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?

- ☐ ABO or other allotypic RBC antigen incompatibility is known.
- ☐ Only transfusion-related (i.e., immune or non-immune) cause of acute hemolysis is present.
- ☐ There are other potential causes present that could explain acute hemolysis, but transfusion is the most likely cause.
- ☐ Other causes of acute hemolysis are more 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

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)

- | | | | | |
|---|---|---|---|------------------------------------|
| <input type="checkbox"/> Antipyretics | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Inotropes/Vasopressors | <input type="checkbox"/> Bronchodilator | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> Intravenous Immunoglobulin | <input type="checkbox"/> Intravenous steroids | <input type="checkbox"/> Corticosteroids | <input type="checkbox"/> 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?
^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

