



## Hemovigilance Module Adverse Reaction Delayed Serologic 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 25 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).

## Delayed Serologic 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

\* **Delayed serologic transfusion reaction (DSTR)**

Antibody(ies): \_\_\_\_\_

#### \*Case Definition

Check all that apply:

- Absence of clinical signs of hemolysis
- Positive direct antiglobulin test (DAT)
- Demonstration of new, clinically-significant antibodies against red blood cells
- Positive antibody screen with newly identified RBC alloantibody
- None of the above

*Continued >>*

## Delayed Serologic Transfusion Reaction

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
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) _____	
<b>*Severity</b>	
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
<b>*Imputability</b>	
Which best describes the relationship between the transfusion and the reaction?	
<input type="checkbox"/> Transfusion performed by your facility is the only possible cause for seroconversion.	
<input type="checkbox"/> The patient has other exposures (e.g. transfusion by another facility or pregnancy) that could explain seroconversion, but transfusion by your facility is the most likely cause.	
<input type="checkbox"/> The patient was transfused by your facility, but other exposures are present that most likely explain seroconversion.	
<input type="checkbox"/> Evidence is clearly in favor of a cause other than the transfusion, but transfusion cannot be excluded.	
<input type="checkbox"/> There is conclusive evidence beyond reasonable doubt of a cause other than the transfusion.	
<input type="checkbox"/> The relationship between the adverse reaction and the transfusion is unknown or not stated.	
Did the transfusion occur at your facility? <input type="checkbox"/> YES <input type="checkbox"/> NO	
When was the new alloantibody identified?	
<input type="checkbox"/> Occurred between 24 hours and 28 days after cessation of transfusion	
<input type="checkbox"/> Occurred less than 24 hours after cessation of transfusion OR greater than 28 days after cessation of transfusion	
<input type="checkbox"/> No new antibody was identified	
<i>Continued &gt;&gt;</i>	

## Delayed Serologic Transfusion Reaction

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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 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 >>*

## Delayed Serologic 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? <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?
<b>^IMPLICATED UNIT</b>						
____/____/____ ____:____:____ ____/____/____ ____:____:____	<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
____/____/____ ____:____:____ ____/____/____ ____:____:____	<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
_____/_____/_____ _____ _____ _____	_____/_____/_____ _____ _____ _____
<b>Comments</b>	
_____ _____ _____	

## 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Hemovigilance Module Additional Worksheet

Transfusion History
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></b></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></b></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></b></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>



## Hemovigilance Module Additional Worksheet

Component Details						
*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?
____/____/____ ____:____ ____/____/____ ____:	<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"/> Entire unit	_____ _____ _____	____/____/____ _____ _____ _____ ____:	<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"/> Codabar _____	<input type="checkbox"/> Partial unit _____ mL	_____ _____	_____ : _____	<input type="checkbox"/> A- <input type="checkbox"/> B + <input type="checkbox"/> <input type="checkbox"/> O-	<input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> AB+ <input type="checkbox"/> N/A	_____
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