



## Hemovigilance Module Adverse Reaction Transfusion Associated Circulatory Overload

\*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  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 circulatory overload (TACO)**

#### \*Case Definition

**Check all that** occurred **within 6 hours** of cessation of transfusion (new onset or exacerbation):

- Acute respiratory distress (dyspnea, orthopnea, cough)
- Elevated brain natriuretic peptide (BNP)
- Elevated central venous pressure (CVP)
- Evidence of left heart failure
- Evidence of positive fluid balance
- Radiographic evidence of pulmonary edema

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	
	<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:  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?  
 No treatment required  Symptomatic treatment only  
 Hospitalization, including prolonged hospitalization  Life-threatening reaction  
 Disability and/or incapacitation  Congenital anomaly or birth defect(s) of the fetus  
 Other medically important conditions  Death  Unknown or not stated

**\*Imputability**  
 Which best describes the relationship between the transfusion and the reaction?  
 No other explanations for circulatory overload are possible.  
 Transfusion is a likely contributor to circulatory overload  
 The patient has a history of a pre-existing condition(s) that most likely explains circulatory overload.  
 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  
 Does the patient have a history of cardiac insufficiency?  
 Yes, the patient has a history of cardiac insufficiency that could explain the circulatory overload, but transfusion is just as likely to have caused the circulatory overload.  
 Yes, the patient has a history of pre-existing cardiac insufficiency that most likely explains circulatory overload.  
 No, the patient does not have a history of cardiac insufficiency.  
 Did the patient received other fluids in addition to the transfusion?  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?
<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

### Custom Fields

Label	Label
_____	_____
_____	_____

**Comments**

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