



Hemovigilance Module Adverse Reaction Transfusion Associated Dyspnea

*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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Transfusion Associated Dyspnea

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 DSTTR 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 dyspnea (TAD)

*Case Definition

Check all that apply:

- Acute respiratory distress occurring within 24 hours of cessation of transfusion.
- Allergic reaction, TACO, and TRALI definitions are not applicable.

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:	<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	

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?

- Patient has no other conditions that could explain symptoms.
- There are other potential causes that could explain symptoms, but transfusion is the most likely cause.
- Other present causes are most 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*)
 - 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
