



Hemovigilance Module Adverse Reaction Transfusion Associated Graft vs. Host Disease

*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 / Transitional Rh Transitional ABO / Rh + Transitional ABO / Rh - 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: _____

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).



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

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 graft vs. host disease (TA-GVHD)

*Case Definition

Did patient receive non-irradiated blood product(s) in the two months preceding the reaction? Yes No

Check all that occurred within 2 days to 6 weeks after cessation of transfusion:

- Clinical syndrome
 Clinical syndrome characteristics: Diarrhea Fever Hepatomegaly Pancytopenia
 Liver dysfunction (i.e., elevated ALT, AST, Alkaline phosphatase, and bilirubin) Marrow aplasia
 Characteristic rash: erythematous, maculopapular eruption centrally that spreads to extremities and may, in severe cases, progress to generalized erythroderma and hemorrhagic bullous formation.

Check all that apply:

- Characteristic histological appearance of skin or liver biopsy.
 Biopsy negative or not done.

Other signs and symptoms: (check all that apply)

Generalized:	<input type="checkbox"/> Chills/rigors	<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"/> Other rash	<input type="checkbox"/> Pruritus (itching)
		<input type="checkbox"/> Jaundice
		<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"/> Bronchospasm	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath	
<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?

- No other alternative diagnoses.
- Other potential causes are present (e.g., stem cell transplantation).
- Alternative explanations are more likely (e.g., solid organ transplantation).
- 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

WBC chimerism: WBC chimerism present WBC chimerism not present or not done

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	
<input type="checkbox"/> Antithymocyte globulin	<input type="checkbox"/> Cyclosporin	<input type="checkbox"/> 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



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