



Hemovigilance Module Adverse Reaction Other 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 >>

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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).

CDC 57.320 (Front) Rev 1, v8.8

Other Transfusion Reaction

Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.)	
<p>(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)</p> <p>Code: _____ Description: _____</p> <p>Code: _____ Description: _____</p> <p>Code: _____ Description: _____</p>	<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NONE
<p>(part 5) Additional Information _____</p> <p>_____</p> <p>_____</p>	

Transfusion History (Use worksheet on page 4 for additional transfusion history.)
<p>*Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN</p> <p>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</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>

Reaction Details
<p>*Date reaction occurred: ___/___/___ *Time reaction occurred: ___:___ <input type="checkbox"/> Time unknown</p> <p>*Facility location where patient was transfused: _____</p> <p>*Is this reaction associated with an incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Incident #: _____</p> <p>After recognition of the transfusion reaction, was the current transfusion:</p> <p><input type="checkbox"/> Continued <input type="checkbox"/> Stopped and restarted <input type="checkbox"/> Stopped indefinitely</p>

Investigation Results
<p>* <input type="checkbox"/> Other</p> <p>Specify: _____</p>
<p>List tests relevant to reaction investigation:</p> <p>Test name: _____ Testing date: _____ Test result: _____</p> <p>Test name: _____ Testing date: _____ Test result: _____</p>
<i>Continued >></i>

Other 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	
	<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? (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 |

***Imputability**

Which best describes the relationship between the transfusion and the reaction?

- Conclusive evidence exists that the adverse reaction can be attributed to the transfusion.
- Evidence is clearly in favor of attributing the adverse reaction to the transfusion.
- Evidence is indeterminate for attributing the adverse reaction to the transfusion or an alternate cause.
- 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

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 _____

Continued >>

Other Transfusion Reaction

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 >>

Other 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?
^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
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Custom Fields	
Label	Label
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Comments	
_____ _____ _____ _____	

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: _____
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(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: _____
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UNKNOWN
 NONE

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(part 5) Additional Information _____

Hemovigilance Module Additional Worksheet

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Hemovigilance Module Additional Worksheet

Component Details						
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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?
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_____ : _____ _____ / _____ / _____ _____ : _____	<input type="checkbox"/> Codabar _____	unit <input type="checkbox"/> Partial unit _____ mL	_____ _____	_____ : _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">A-</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> B</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">+</td> <td style="text-align: center;">AB-</td> <td style="text-align: center;">AB+</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">O-</td> <td style="text-align: center;"><input type="checkbox"/> O+</td> <td style="text-align: center;">N/A</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	A-				<input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	+	AB-	AB+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O-	<input type="checkbox"/> O+	N/A	<input type="checkbox"/>
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