



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 ☐ 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 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:	☐ Chills/rigors	☐ Fever	☐ Nausea/vomiting
Cardiovascular:	☐ Blood pressure decrease	☐ Shock	
Cutaneous:	☐ Edema	☐ Flushing	☐ Jaundice
	☐ Other rash	☐ Pruritus (itching)	☐ Urticaria (hives)
Hemolysis/Hemorrhage:	☐ Disseminated intravascular coagulation	☐ Hemoglobinemia	
	☐ Positive antibody screen		
Pain:	☐ Abdominal pain	☐ Back pain	☐ Flank pain
Renal:	☐ Hematuria	☐ Hemoglobinuria	☐ Oliguria

☐ Infusion site
pain

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?
^IMPLICATED UNIT						
____/____/____ ____:____:____	☐ ISBT-128 ☐ Codabar	☐ Entire unit ☐ Partial unit mL	____-____-____ ____-____-____	____/____/____ ____:____:____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	Y
____/____/____ ____:____:____	☐ ISBT-128 ☐ Codabar	☐ Entire unit ☐ Partial unit mL	____-____-____ ____-____-____	____/____/____ ____:____:____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N

Custom Fields

Label	Label
____/____/____	____/____/____
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