**Hemovigilance Module**

**Adverse Reaction**

**Other Transfusion Reaction**

\*Required for saving

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| \*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 |

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| **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 >>* | | | | |
| 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).  CDC 57.320 (Front) Rev 1, v8.8 | | | | |

**Other Transfusion Reaction**

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| **Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.)** | | | | |
|  | **(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)* | | | UNKNOWN |
| NONE |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | **(part 5)** Additional Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **Transfusion History (Use worksheet on page 4 for additional transfusion history.)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | \*Has the patient received a previous transfusion? | | | | | | | | | | | | | | | YES | | | | NO | | | | UNKNOWN | | | |
|  | *\*\*If yes, provide information about the transfusion event. If not, skip to Reaction Details section.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Blood Product: | | | WB | | | RBC | | Platelet | | | | Plasma | | | | | Cryoprecipitate | | | | | | | Granulocyte | |
|  | | | Date of Transfusion: | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | UNKNOWN | | | | | | | | | | | | | | | | |
|  | | | Did the patient experience a transfusion adverse reaction? | | | | | | | | | | | | | | | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |

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| **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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| After recognition of the transfusion reaction, was the current transfusion: | | | | | | | | |
| Continued | Stopped and restarted | | | | Stopped indefinitely | | | |
|  | | | | | | | | |

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| **Investigation Results** | | | | | | | |
| \* **Other** | | | | | | | |
|  | | Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | | | |
|  | List tests relevant to reaction investigation: | | | | | | |
|  | | Test name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Testing date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Test result: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | | Test name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Testing date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Test result: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | | | | | | | |
| *Continued >>* | | | | | | | |

**Other Transfusion Reaction**

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| **Investigation Results (continued)** | | | | | | | | | | | | | | | | | | |
|  | 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 | | | | | | Infusion site pain | | |
|  | | Renal: | | Hematuria | | | Hemoglobinuria | | | | | | | | 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? *(Response definitions listed in protocol)* | | | | | | | | | | | | | | | | |
|  | | | Symptomatic treatment only | | Hospitalization, inlcuding prolonged hospitalization | | | | | | | | | | | | | |
|  | | | Life-threatening reaction | | | | Disability and/or incapacitation | | | | | | | | | | | |
|  | | | Congenital anomaly or birth defect(s) of the fetus | | | | | | | | | | | Death | | | | |
|  | | | Other medically important conditions | | | | | | | | | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
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**Other Transfusion Reaction**

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
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| **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 | | | | | |
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**Other Transfusion Reaction**

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| **Component Details (Use worksheet on page 4 for additional units.)** | | | | | | | | | | | |
| \*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 | \*Unit expiration Date/Time | | \*Blood group of unit | | | | | Implicated  Unit? |
| **^IMPLICATED UNIT** | | | | | | | | | | | |
| \_\_\_\_/\_\_\_\_/\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | A+ | | B- | | Y |
| \_\_\_ \_\_\_:\_\_\_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | AB- | | AB+ | |
| \_\_\_ \_\_\_:\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | O+ | | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | A+ | | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | AB- | | AB+ | |
| \_\_\_ \_\_\_:\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | O+ | | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | A+ | | B- | | N |
| \_\_\_ \_\_\_:\_\_\_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | AB- | | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | O+ | | N/A | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Custom Fields** | | | |
| Label |  | Label |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | **(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)* | | | | UNKNOWN |
| NONE |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | **(part 5)** Additional Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

**Hemovigilance Module**

**Additional Worksheet**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Transfusion History** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Has the patient received a previous transfusion? | | | | | | | | | | | | | | | YES | | | | NO | | | | | | |
|  | *\*\*If yes, provide information about the transfusion event. If not, skip to Reaction Details section.* | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Blood Product: | | | WB | | | RBC | | Platelet | | | | Plasma | | | | | Cryoprecipitate | | | | | | Granulocyte | |
|  | | | Date of Transfusion: | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | UNKNOWN | | | | | | | | | | | | | | | |
|  | | | Did the patient experience a transfusion adverse reaction? | | | | | | | | | | | | | | | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | Has the patient received a previous transfusion? | | | | | | | | | | | | | | | YES | | | | NO | | | | | | |
|  | *\*\*If yes, provide information about the transfusion event. If not, skip to Reaction Details section.* | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Blood Product: | | | WB | | | RBC | | Platelet | | | | Plasma | | | | | Cryoprecipitate | | | | | | Granulocyte | |
|  | | | Date of Transfusion: | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | UNKNOWN | | | | | | | | | | | | | | | |
|  | | | Did the patient experience a transfusion adverse reaction? | | | | | | | | | | | | | | | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | Has the patient received a previous transfusion? | | | | | | | | | | | | | | | YES | | | | NO | | | | | | |
|  | *\*\*If yes, provide information about the transfusion event. If not, skip to Reaction Details section.* | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Blood Product: | | | WB | | | RBC | | Platelet | | | | Plasma | | | | | Cryoprecipitate | | | | | | Granulocyte | |
|  | | | Date of Transfusion: | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | UNKNOWN | | | | | | | | | | | | | | | |
|  | | | Did the patient experience a transfusion adverse reaction? | | | | | | | | | | | | | | | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | | | | | | | | | | | | | | | | |

**Hemovigilance Module**

**Additional Worksheet**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | \*Unit expiration Date/Time | | \*Blood group of unit | | | | | Implicated  Unit? |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | | A+ | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | | AB- | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | | O+ | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | | A+ | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | | AB- | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | | O+ | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | | A+ | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | | AB- | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | | O+ | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | | A+ | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | | AB- | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | | O+ | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | | A+ | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | | AB- | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | | O+ | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | | A+ | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | | AB- | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | | O+ | N/A | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | ISBT-128 | Entire unit  Partial unit  \_\_\_\_\_\_mL | \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | | A- | | A+ | B- | | N |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | Codabar | \_\_ \_\_ |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_ : \_\_\_\_\_ | | B+ | | AB- | AB+ | |
| \_\_\_ \_\_\_:\_\_\_ \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ | O- | | O+ | N/A | |