



Hemovigilance Module Adverse Reaction Acute Hemolytic 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
 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: _____

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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 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

* Acute hemolytic transfusion reaction (AHTR)
 Immune Antibody: _____ Non-immune (specify) _____

*Case Definition

Check the following that occurred during, or within 24 hours of cessation of transfusion with **new** onset:

- Back/flank pain Chills/rigors Epistaxis Disseminated intravascular coagulation (DIC)
- Oliguria/anuria Hypotension Fever Hematuria (gross visual hemolysis)
- Pain and/or oozing at IV site Renal failure

Check all that apply: Decreased fibrinogen Decreased haptoglobin Elevated bilirubin
 Elevated LDH Hemoglobinemia Hemoglobinuria Plasma discoloration c/w hemolysis

- Spherocytes on blood film Positive direct antiglobulin test (DAT) for anti-IgG or anti-C3
- Positive elution test with alloantibody present on the transfused red blood cells
- Serologic testing is negative, and physical cause (e.g., thermal, osmotic, mechanical, chemical) is confirmed.
- Physical cause is excluded but serologic evidence is not sufficient to meet definitive criteria.
- Physical cause is suspected and serologic testing is negative.
- AHTR is suspected, but symptoms, test results, and/or information are not sufficient to confirm reaction.

Other signs and symptoms: (check all that apply)

Generalized: Nausea/vomiting
 Cardiovascular: 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"/> Hemoglobinemia	<input type="checkbox"/> Positive antibody screen	
Pain:	<input type="checkbox"/> Abdominal pain		
Respiratory:	<input type="checkbox"/> Bilateral infiltrates on chest x-ray	<input type="checkbox"/> Bronchospasm	<input type="checkbox"/> Cough
	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Hypoxemia	
<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?

- ABO or other allotypic RBC antigen incompatibility is known.
- Only transfusion-related (i.e., immune or non-immune) cause of acute hemolysis is present.
- There are other potential causes present that could explain acute hemolysis, but transfusion is the most likely cause.
- Other causes of acute hemolysis are more 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*)

<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	

- 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						
____/____/____ ____:____	<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

