



## Hemovigilance Module Adverse Reaction Allergic 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 / Rh +  Transitional ABO / Rh -  Transitional ABO / Transitional 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

\* Allergic reaction, including anaphylaxis

#### \*Case Definition

Check the following that occurred during or within **4 hours** of cessation of transfusion:

Conjunctival edema  Edema of lips, tongue and uvula  Localized angioedema  Hypotension

Erythema and edema of the periorbital area  Respiratory distress; bronchospasm  Urticaria

Generalized flushing  Maculopapular rash  Pruritus

Other signs and symptoms: (check all that apply)

Generalized:  Chills/rigors  Fever  Nausea/vomiting

Cardiovascular:  Shock

Cutaneous:  Jaundice

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  Cough

Hypoxemia  Shortness of breath

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 evidence of environmental, drug or dietary risks.
- There are other potential causes present that could explain acute hemolysis, but transfusion is the most likely cause.
- Other present causes are most 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

When did the reaction occur in relation to the transfusion?

- Occurred during or within 2 hours of cessation of transfusion.
- Occurred 2 - 4 hours after cessation of transfusion.

Did the same reaction occur after the transfusion was restarted (rechallenge)?  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?
___/___/___ : ___/___/___ :	<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**