



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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Other Transfusion Reaction

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 _____

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 _____

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

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

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
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)*

- | | | | | |
|---|---|---|---|------------------------------------|
| <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 | |
| <input type="checkbox"/> Antithymocyte globulin | <input type="checkbox"/> Cyclosporin | <input type="checkbox"/> H1 receptor blockers | <input type="checkbox"/> 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+	Y
					<input type="checkbox"/> AB-	<input type="checkbox"/> AB+	<input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A	
____/____/____ ____:____:____ ____/____/____ ____:____:____	<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+	N
					<input type="checkbox"/> AB-	<input type="checkbox"/> AB+	<input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A	
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					<input type="checkbox"/> AB-	<input type="checkbox"/> AB+	<input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> 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: _____
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Code: _____	Description: _____
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Code: _____	Description: _____
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(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)*

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Code: _____	Description: _____
Code: _____	Description: _____
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Code: _____	Description: _____

(part 5) Additional Information _____

Hemovigilance Module Additional Worksheet

Transfusion History
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></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"/> DSTTR <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>
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Hemovigilance Module Additional Worksheet

Component Details						
*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?
____/____/____ ____:____ ____/____/____ ____:____	<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
____/____/____ ____:____ ____/____/____ ____:____	<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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_____ : _____ _____ / _____ / _____ _____ : _____	<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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