

Hemovigilance Module Adverse Reaction Hypotensive Transfusion Reaction

*Required for saving

*Facility ID#: _____ NHSN Adverse Reaction #: _____

Patient Information

*Patient ID: _____ *Gender: M F Other *Date of Birth: ___/___/___

Sex at Birth: M F Unknown Gender Identity (Specify): _____

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

* Hypotensive transfusion reaction

*Case Definition

Check all that occurred during or within 1 hour of cessation of transfusion:

- All other adverse reactions presenting with hypotension are excluded.
- Hypotension

Check all that apply:

- Hypotension occurs, does not meet the criteria above. Other, more specific reaction definitions do not apply.

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"/> 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 <input type="checkbox"/> Infusion site 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?

- | | |
|---|---|
| <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?

- The patient has no other conditions that could explain hypotension.
- There are other potential causes present that could explain hypotension, but transfusion is the most likely cause.
- Other conditions that could readily explain hypotension are present.
- 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.

How did the patient respond to the cessation of transfusion and supportive treatment?

- Responds rapidly (i.e., within 10 minutes) to cessation of transfusion and supportive treatment.
- The patient does not respond rapidly to cessation of transfusion and supportive treatment.

Did the transfusion occur at your facility? YES NO

When did the reaction occur in relation to the transfusion?

- Occurs less than 15 minutes after the start of the transfusion.
- Onset is between 15 minutes after start and 1 hour after cessation of transfusion.

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
