



## 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:    | <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"/> 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?
<b>^IMPLICATED UNIT</b>						
____/____/____ ____:____	<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

