

## Hemovigilance Module Adverse Reaction Febrile Non-hemolytic Transfusion Reaction

*Required for saving
*Facility ID#: NHSN Adverse Reaction #:
Patient Information
*Patient ID:       *Gender:       M       F       Other       *Date of Birth:       I
Sex at Birth: $\Box$ M $\Box$ F $\Box$ Unknown Gender Identity (Specify):
Social Security #:
Last 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
*Blood Group:       A-       A+       B-       B+       AB-       O-       O+       Blood type not done         Transitional ABO / Transitional
Transitional ABO / Rh + Transitional ABO / Rh - Rh Group A/Transitional Group B/Transitional Rh 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 UNKNOWN reaction. (Use ICD-10 Diagnostic codes/descriptions)
Code: Description:
Code: Description:
Code: Description:
Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).
Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of informatior unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-

collection of information, including suggestions for reducing 74, Atlanta, GA 30333 ATTN: PRA (0920-0666).



## Febrile Non-hemolytic Transfusion Reaction

	nedical procedure including past procedures and procedures to be       UNKNOWN         nt hospital or outpatient stay. (Use ICD-10 Procedure       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 advers	e reaction transfusion-related?							
	n about the transfusion adverse reaction.							
Type of transfusion adve	rse reaction:AllergicAHTRDHTRDSTRFNHTR							
HTR TTI PTP TACO TAD TA-GVHD TRALI UNKNOWN								
OTHER Speci	fy							
Reaction Details								
	// *Time reaction occurred:: Time unknown							
*Facility location where pati								
Is this reaction associated with	h an incident? Yes No If Yes, Incident #:							
Investigation Results								
	c transfusion reaction (FNHTR)							
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* Febrile non-hemolytic *Case Definition	c transfusion reaction (FNHTR) uring or within 4 hours of cessation of transfusion:							
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Other: (specify)         *Severity         Did the patient receive or experience any of the following?         No treatment required       Symptomatic treatment only         Hospitalization, inlcuding prolonged hospitalization       Life-threatening reaction         Disability and/or incapacitation       Congenital anomaly or birth defect(s) of the fetus         Other medically important conditions       Death       Unknown or not stated         *Imputability       Which best describes the relationship between the transfusion and the reaction?       Patient has no other conditions that could explain signs/symptoms.         There are other potential causes present that could explain signs/symptoms, but transfusion is the most likely cause.       Other resent 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.         Did the transfusion occur at your facility?       YES       NO         Module-generated Designations       YES       NO
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application based on responses in the corresponding investigation results section above
application based on responses in the corresponding investigation results section above.
*Do you agree with the <u>case definition</u> 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 <i>imputability</i> designation?
APlease indicate your designation
Patient Treatment
Did the patient receive treatment for the transfusion reaction?
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
Antithymocyte globulin Cyclosporin Other
Antithymocyte globulin Cyclosporin Other
Antithymocyte globulin Cyclosporin Other Volume resuscitation (Intravenous colloids or crystalloids) Respiratory support <i>(Select the type of support)</i>

National H Safety N		Peritoneal	Continuous Ver	no-Venous Hemo	Form App OMB No. 0920 Exp. Date: 12 www.cdc.gov ofiltration	)-0666 /31/22				
Phle	ebotomy er 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?										
Component Details         *Was a particular unit implicated in (i.e., responsible for) the adverse reaction?										
Transfusion Start and <b>End</b> <b>Date/Time</b>	*Component code (check system used)	Amount transfused at reaction onset	AUnit number (Required for Infection and TRALI)	*Unit expiration Date/Time	*Blood group of unit	Implic ated Unit?				
^IMPLICATED	UNIT									
// : :	ISBT-128         Codabar         — — — — — —	Entire unit Partial unit mL			A- A+ B- B+ AB- AB+ O- O+ N/A	Y				
// : //	ISBT-128	Entire unit Partial unit mL			A- A+ B- B+ AB- AB+ O- O+ N/A	N				
Custom Field	ds									
Label			Label		, ,					
		<u> </u>			//					
Comments										