



## 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: \_\_\_/\_\_\_/\_\_\_

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: \_\_\_\_\_

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 information 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-74, Atlanta, GA 30333 ATTN: PRA (0920-0666).

## Febrile Non-hemolytic Transfusion Reaction

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

\* **Febrile non-hemolytic transfusion reaction (FNHTR)**

**\*Case Definition**

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

Fever (greater than or equal to 38°C/100.4°F oral and a change of at least 1°C/1.8°F) from pre-transfusion value

Chills/rigors are present

**Check all that apply:**

FNHTR is suspected, but reported symptoms and/or available information are not sufficient.

Other signs and symptoms: (check all that apply)

|                       |  |
|-----------------------|--|
| Generalized:          | <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 <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                         |

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?

- 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 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

**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? |
|-------------------------------------|---|--|---|----------------------------|--|------------------|
| <b>^IMPLICATED UNIT</b>             |   |  |   |                            |  |                  |
| ____/____/____<br>:____             | <input type="checkbox"/> ISBT-128<br><input type="checkbox"/> Codabar | <input type="checkbox"/> Entire unit<br><input type="checkbox"/> Partial unit mL | ____-____<br>____-____                          | ____/____/____<br>:____    | <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B-<br><input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+<br><input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A | Y                |
| ____/____/____<br>:____             | <input type="checkbox"/> ISBT-128<br><input type="checkbox"/> Codabar | <input type="checkbox"/> Entire unit<br><input type="checkbox"/> Partial unit mL | ____-____<br>____-____                          | ____/____/____<br>:____    | <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B-<br><input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+<br><input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A | N                |

**Custom Fields**

| Label          | Label          |
|----------------|----------------|
| ____/____/____ | ____/____/____ |
| ____           | ____           |

**Comments**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_