



## Hemovigilance Module Adverse Reaction Post Transfusion Purpura

\*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).



Form Approved  
OMB No. 0920-0666  
Exp. Date: 12/31/22  
[www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)

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  DSTTR  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

\* Post transfusion purpura (PTP)

#### \*Case Definition

Check all that occurred after cessation of transfusion :

- Alloantibodies in the patient directed against HPA or other platelet specific antigen detected at or after development of thrombocytopenia.
- Thrombocytopenia (i.e., decrease in platelets to less than 20% of pre-transfusion count).
- Decrease in platelets to levels between 20% and 80% of pre-transfusion count.

Check all that apply:

- PTP is suspected, but laboratory findings and/or information are not sufficient. NOTE: For example, the patient has a drop in platelet count to less than 80% of pre-transfusion count but HPA antibodies were not tested or were negative.

Other signs and symptoms: (check all that apply)

<b>Generalized:</b>	<input type="checkbox"/> Chills/rigors	<input type="checkbox"/> Fever	<input type="checkbox"/> Nausea/vomiting
<b>Cardiovascular:</b>	<input type="checkbox"/> Blood pressure decrease	<input type="checkbox"/> Shock	
<b>Cutaneous:</b>	<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)
<b>Hemolysis/Hemorrhage:</b>	<input type="checkbox"/> Disseminated intravascular coagulation	<input type="checkbox"/> Hemoglobinemia	
	<input type="checkbox"/> Positive antibody screen		
<b>Pain:</b>	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Flank pain <input type="checkbox"/> Infusion site pain
<b>Renal:</b>	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Hemoglobinuria	<input type="checkbox"/> Oliguria

**Respiratory:**

- Bilateral infiltrates on chest x-ray     Bronchospasm     Cough  
 Hypoxemia     Shortness of breath

Other: (specify) \_\_\_\_\_

**\*Severity**

Did the patient receive or experience any of the following?

- No treatment required     Symptomatic treatment only  
 Hospitalization, including 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 to explain thrombocytopenia.  
 There are other potential causes present that could explain thrombocytopenia, but transfusion is the most likely cause.  
 Alternate explanations for thrombocytopenia 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

When did the reaction occur in relation to the transfusion?

- Occurred 5-12 days post-transfusion  
 Occurred less than 5 or more than 12 days post-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*)  
 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?
-------------------------------------	-------------------------------------	-------------------------------------	---	----------------------------	----------------------	------------------

**^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**

\_\_\_\_\_

