



Hemovigilance Module Adverse Reaction Transfusion Related Acute Lung Injury

*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

*☐ Transfusion related acute lung injury (TRALI)

		Not Done	Negative	Test result positive		
				Cognate or cross reacting antigen present	No cognate or cross reacting antigen present	Not tested for cognate antigen
Donor or unit HLA specificity		☐	☐	☐	☐	☐
Donor or unit HNA specificity		☐	☐	☐	☐	☐
Recipient HLA specificity		☐	☐	☐	☐	☐
Recipient HNA specificity		☐	☐	☐	☐	☐

*Case Definition (Check all that apply)

- ☐ NO evidence of acute lung injury (ALI) prior to transfusion.
- ☐ ALI onset during or within 6 hours of cessation of transfusion
- ☐ Hypoxemia – defined as PaO₂/FiO₂ less than or equal to 300 mm Hg
- ☐ Hypoxemia – defined as Oxygen saturation less than 90% on room air
- ☐ Hypoxemia – defined as Other clinical evidence
- ☐ Radiographic evidence of bilateral infiltrates
- ☐ No evidence of left atrial hypertension (i.e., circulatory overload)

Other signs and symptoms: (check all that apply)

Generalized: ☐ Chills/rigors ☐ Fever ☐ Nausea/vomiting

Cardiovascular: ☐ Blood pressure decrease ☐ Shock

Cutaneous: ☐ Edema ☐ Flushing ☐ Jaundice ☐ Itching ☐ Other rash

	Hives	
Hemolysis/Hemorrhage:	☐ DIC ☐ Hemoglobinemia ☐ Positive antibody screen	
Pain:	☐ Abdominal pain ☐ Back pain ☐ Flank pain ☐ Infusion site pain	
Renal:	☐ Hematuria ☐ Hemoglobinuria ☐ Oliguria	
Respiratory:	☐ Bronchospasm ☐ Cough ☐ 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?

- ☐ There are no alternative risk factors for ALI present.
- ☐ There is evidence of other causes for acute lung injury.
- ☐ 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?
^IMPLICATED UNIT						
____/____/____ ____:____ ____/____/____ ____:	☐ ISBT-128 ☐ Codabar	☐ Entire unit ☐ Partial unit mL	____-____-____ ____-____-____	____/____/____ ____:____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	Y
____/____/____ ____:____ ____/____/____ ____:	☐ ISBT-128 ☐ Codabar	☐ Entire unit ☐ Partial unit mL	____-____-____ ____-____-____	____/____/____ ____:____	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N

Custom Fields

Label	Label
_____ _____ _____/_____/_____ _____	_____ _____ _____/_____/_____ _____

Comments

