



Hemovigilance Module Adverse Reaction Transfusion Associated Graft vs. Host Disease

*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: _____

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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 associated graft vs. host disease (TA-GVHD)

*Case Definition

Did patient receive non-irradiated blood product(s) in the two months preceding the reaction? ☐ Yes ☐ No

Check all that occurred within 2 days to 6 weeks after cessation of transfusion:

☐ Clinical syndrome

Clinical syndrome characteristics: ☐ Diarrhea ☐ Fever ☐ Hepatomegaly ☐ Pancytopenia

☐ Liver dysfunction (i.e., elevated ALT, AST, Alkaline phosphatase, and bilirubin) ☐ Marrow aplasia

☐ Characteristic rash: erythematous, maculopapular eruption centrally that spreads to extremities and may, in severe cases, progress to generalized erythroderma and hemorrhagic bullous formation.

Check all that apply:

☐ Characteristic histological appearance of skin or liver biopsy.

☐ Biopsy negative or not done.

Other signs and symptoms: (check all that apply)

Generalized: ☐ Chills/rigors ☐ Nausea/vomiting

Cardiovascular: ☐ Blood pressure decrease ☐ Shock

Cutaneous: ☐ Edema ☐ Flushing ☐ Jaundice
☐ Other rash ☐ Pruritus (itching) ☐ Urticaria (hives)

Hemolysis/Hemorrhage:	☐ Disseminated intravascular coagulation	☐ 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?

- ☐ No other alternative diagnoses.
- ☐ Other potential causes are present (e.g., stem cell transplantation).
- ☐ Alternative explanations are more likely (e.g., solid organ transplantation).
- ☐ 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

WBC chimerism: ☐ WBC chimerism present ☐ WBC chimerism not present or not done

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



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