



*Required for saving

Hemovigilance Module Adverse Reaction Delayed Serologic Transfusion Reaction

*Facility ID#: ____ NHSN Adverse Reaction #: **Patient Information** *Gender: M F *Patient ID: Other *Date of Birth: ____/___ Medicare #: _____ Social Security #: _____ Secondary ID: _____ First Name: _____ Middle Name: ____ Last Name: Ethnicity Hispanic or Latino Not Hispanic or Not Latino Asian American Indian/Alaska Native Black or African American Race Native Hawaiian/Other Pacific Islander White *Blood Group: A- A+ B- B+ AB+ O-O+ Blood type not done Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.) (part 1) List the patient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions) Code: _____ Description: Description: _____ Code: _____ Code: Description: (part 2) List the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions) Code: _____ Description: Description: Code: _____ Description: Code: (part 3) List the patient's comorbid conditions at the time of the transfusion related to the **UNKNOWN** adverse reaction. (Use ICD-10 Diagnostic codes/descriptions) NONE Code: _____ Description: Description: _____ Code: _____ Code: Description: Continued >> 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 25 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). CDC 57.310 Rev.1 v8.8



Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.)
(part 4) 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)
Code: Description:
Code: Description:
Code: Description:
(part 5) Additional Information
Transfusion History (Use worksheet on page 4 for additional transfusion history.)
*Has the patient received a previous transfusion? YES NO UNKNOWN
**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.
Blood Product: WB RBC Platelet Plasma Cryoprecipitate Granulocyte
Date of Transfusion:/ UNKNOWN
Did the patient experience a transfusion adverse reaction? YES NO
If yes, provide information about the transfusion adverse reaction. Type of transfusion adverse reaction: Allergic AHTR DHTR DSTR FNHTR
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 #:
After recognition of the transfusion reaction, was the current transfusion:
Continued Stopped and restarted Stopped indefinitely
Investigation Results
* Delayed serologic transfusion reaction (DSTR)
Antibody(ies):
*Case Definition
Check all that apply:
Absence of clinical signs of hemolysis
Positive direct antiglobulin test (DAT)
Demonstration of new, clinically-significant antibodies against red blood cells
Positive antibody screen with newly identified RBC alloantibody
None of the above
Continued >>



Investigation Results (con	ntinued)							
Other signs and symptoms:	(check all that apply)							
Generalized:	Chills/rigors	Fever	Nausea/vomiting					
Cardiovascular:	Blood pressure dec	Blood pressure decrease Shock						
Cutaneous:	Jaundice							
Cutaneous.	Other rash	Other rash Pruritus (itching) Urticaria (hives)						
Hemolysis/Hemorrhage:	Disseminated intrav	vascular coagulation Hemo	oglobinemia					
Pain:	Abdominal pain	Back pain Flank pain	Infusion site pain					
Renal:	Hematuria	Hemoglobinuria	Oliguria					
Respiratory:	Bilateral infiltrates o	on chest x-ray 🔲 Bronchospa	asm Cough					
respiratory.	Hypoxemia	Shortness	of breath					
Other: (specify)			· · · · · · · · · · · · · · · · · · ·					
<u>*Severity</u>								
Did the patient receive or e	experience any of the follo	owing? (Response definitions lis	ted in protocol)					
Symptomatic treatm	nent only Hospita	alization, inlcuding prolonged ho	ospitalization					
Life-threatening rea	ction	Disability and/or incap	acitation					
Congenital anomaly	or birth defect(s) of the f	fetus [] [Death					
Other medically imp			nown or not stated					
*Imputability								
,	olationship hotwoon the t	ransfusion and the reaction?						
	•	nly possible cause for seroconve	orgion					
-		sion by another facility or pregna						
		is the most likely cause.	arioy) triat oodid explain					
	sfused by your facility, bu	t other exposures are present th	nat most likely explain					
seroconversion.								
Evidence is clearly in	favor of a cause other th	nan the transfusion, but transfusi	on cannot be excluded.					
There is conclusive e	evidence beyond reasona	ble doubt of a cause other than	the transfusion.					
The relationship betw	veen the adverse reaction	n and the transfusion is unknowr	n or not stated.					
Did the transfusion occur a	t your facility?	ES NO						
When was the new alloanti	body identified?							
Occurred between 24	4 hours and 28 days after	cessation of transfusion						
Occurred less than 2 transfusion	4 hours after cessation of	f transfusion OR greater than 28	days after cessation of					
No new antibody was	s identified							
			Continued >>					



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?
Please indicate your designation
Do you agree with the severity designation?
Please indicate your designation
Do you agree with the imputability designation?
Please indicate your designation
Additional Information
Patient Treatment
*Did the patient receive treatment for the transfusion reaction? YES UNKNOWN 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 H1 receptor blockers 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:
Guier Specify.
Outcome
Outcome Minor or no
*Outcome: Death Major or long-term sequelae sequelae Not determined
Date of Death:/
^*If recipient died, relationship of transfusion to death:
Definite Probable Doubtful Ruled Out Not determined



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Cause of death:			
Was an autopsy performed?	Yes	No	
			Continued >>



Component Details (Use worksheet on page 4 for additional units.)									
*Was a particul	ar unit implicated in	(i.e., responsible for)	the adverse read	ction?	Ye	es	No		I/A
Transfusion Start and End Date/Time	*Component code (check system used)	Amount transfused at reaction onset	Unit number	*Unit expiration Date/Tim		*Bloc	od group	of	Implic ated Unit?
^IMPLICATED U	NIT								
	ISBT-128 Codabar	Entire unit Partial unitmL		<i>1 1</i>		A- B +	A+ A+ AB- O+	B- AB+ N/A	Y
!! :!	ISBT-128 Codabar	Entire unit Partial unitmL				A- B +	A+ A+ AB- O+	B- AB+ N/A	N
	ISBT-128 Codabar	Entire unit Partial unitmL		:		A- B +	A+ AB- O+	B- AB+ N/A	N
Custom Fields									
Label			Label						
					- -	/	'		_
Comments									



Hemovigilance Module Additional Worksheet

	story
(part 1) List the pa	ient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
Code:	
(part 2) List the pat	ent's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions)
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Code:	Description:
Code:	
Code:	
Code:	
Code:	
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Code: Code: Code: Code: Code: (part 4) List the partocedures to be perfocedure codes/de Code:	Description:
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Code: Code: Code: Code: Code: Code: (part 4) List the partocedures to be perfocedure codes/decodes Code: Code: Code: Code: Code: Code:	Description:



Hemovigilance Module Additional Worksheet

Transfusion History
Has the patient received a previous transfusion?
**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.
Blood Product: WB RBC Platelet Plasma Cryoprecipitate Granulocyte
Date of Transfusion:// UNKNOWN
Did the patient experience a transfusion adverse reaction? YES NO
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Hemovigilance Module Additional Worksheet

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	ISBT-128 Codabar	Entire unit Partial unitmL			<u>/</u>	A- B +		B- AB+ N/A	N
	ISBT-128 Codabar	Entire unit Partial unitmL			<i>!</i>	A- B +	A+ AB- O+	B- AB+ N/A	N
	ISBT-128 Codabar	Entire unit Partial unitmL			<u>/</u>	A- B +		B- AB+	N
	ISBT-128 Codabar	Entire unit Partial unitmL			<i>!</i>	A- B +		B- AB+ N/A	N
	ISBT-128 Codabar	Entire unit Partial unitmL			<u>/</u>	A- B +	A+ A+ O+	B- AB+	N
	ISBT-128 Codabar	Entire unit Partial unitmL			:	A- B	A+	B- AB+ N/A	N
	ISBT-128	Entire unit		'	_/		A+	B-	N



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Safety Ne	twork				www.c	:dc.gov/nl	nsn
:	Codabar			A-			
		Partial unitmL	 ::	+ O-		AB+ N/A	