

Hemovigilance Module Adverse Reaction Acute 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).

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

* Acute hemolytic transfusion reaction (AHTR)
 Immune Antibody: _____ Non-immune (specify) _____

*Case Definition

Check the following that occurred during, or within 24 hours of cessation of transfusion with **new** onset:

- Back/flank pain Chills/rigors Epistaxis Disseminated intravascular coagulation (DIC)
- Oliguria/anuria Hypotension Fever Hematuria (gross visual hemolysis)
- Pain and/or oozing at IV site Renal failure

Check all that apply: Decreased fibrinogen Decreased haptoglobin Elevated bilirubin
 Elevated LDH Hemoglobinemia Hemoglobinuria Plasma discoloration c/w hemolysis

- Spherocytes on blood film Positive direct antiglobulin test (DAT) for anti-IgG or anti-C3
- Positive elution test with alloantibody present on the transfused red blood cells
- Serologic testing is negative, and physical cause (e.g., thermal, osmotic, mechanical, chemical) is confirmed.
- Physical cause is excluded but serologic evidence is not sufficient to meet definitive criteria.
- Physical cause is suspected and serologic testing is negative.
- AHTR is suspected, but symptoms, test results, and/or information are not sufficient to confirm reaction.

Other signs and symptoms: (check all that apply)

- | | |
|-----------------|--|
| Generalized: | <input type="checkbox"/> Nausea/vomiting |
| Cardiovascular: | <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"/> Hemoglobinemia	<input type="checkbox"/> Positive antibody screen	
Pain:	<input type="checkbox"/> Abdominal pain		
Respiratory:	<input type="checkbox"/> Bilateral infiltrates on chest x-ray	<input type="checkbox"/> Bronchospasm	<input type="checkbox"/> Cough
	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Hypoxemia	
<input type="checkbox"/> 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?

- ABO or other allotypic RBC antigen incompatibility is known.
- Only transfusion-related (i.e., immune or non-immune) cause of acute hemolysis is present.
- There are other potential causes present that could explain acute hemolysis, but transfusion is the most likely cause.
- Other causes of acute hemolysis 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

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
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Comments

