Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

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: F M Unknown

Gender Identity (Specify):
Male
Female
Male-to-female transgender
Female-to-male transgender
Identifies as non-conforming
Other
Asked but unknown

Social Security #: _____ Secondary ID: _____ Medicare #: _____

Last Name: _____ First Name: _____ Middle Name: _____

Ethnicity (Specify):
Hispanic or Latino
Not Hispanic or Latino
Unknown
Declined to respond

Race (Specify):
(Select all that apply):
American Indian or Alaska Native
Asian
Black or African American
Middle Eastern or North African
Native Hawaiian or Pacific Islander
White
Unknown
Declined to respond

Preferred Language (Specify):_____

Interpreter Needed: ☐Yes ☐No
Declined to Respond Unknown

***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: _____

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)). CDC 57.307 Rev. 3, v9.2

Public reporting burden of this collection of information is estimated to average 22 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 H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

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: _____

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
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 ☐ 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:	☐ Nausea/vomiting
Cardiovascular:	☐ Shock

Cutaneous:	☐ Edema	☐ Flushing	☐ Jaundice
	☐ Other rash	☐ Pruritus (itching)	☐ Urticaria (hives)
Hemolysis/Hemorrhage:	☐ Hemoglobinemia	☐ Positive antibody screen	
Pain:	☐ Abdominal pain		
Respiratory:	☐ Bilateral infiltrates on chest x-ray	☐ Bronchospasm	☐ Cough
	☐ Shortness of breath	☐ Hypoxemia	

☐ Other: (specify) _____

***Severity**

Did the patient receive or experience any of the following?

☐ No treatment required
☐ Symptomatic treatment only
☐ Hospitalization, inlcuding 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?

☐ 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								
____/____/___ ___ ___:____ ____/____/___ ___ ___:____	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _____	☐ Entire unit ☐ Partial unit _____mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____:_____	☐ A- ☐ B+ ☐ O-	☐ A+ ☐ AB- ☐ O+	☐ B- ☐ AB+ ☐ N/A	Y
____/____/___ ___ ___:___ _ ____/____/___ ___ ___:____	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _____	☐ Entire unit ☐ Partial unit _____mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____:_____	☐ A- ☐ B+ ☐ O-	☐ A+ ☐ AB- ☐ O+	☐ B- ☐ AB+ ☐ N/A	N

Custom Fields

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

Comments

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn