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Hemovigilance Module Adverse Reaction Delayed Serologic Transfusion Reaction

*Facility ID#: NHSN Ad	verse Reaction #	:		
Patient Information				
*Patient ID:	*Gender: M	F Other	*Date of Birth://	
*Sex at Birth: M F Unknowr	1		*Gender Identity (Specify): Male Female	
			Male-to-female transgender Female-to-male transgender Identifies as non-conforming	
			Other	
Social Security #:	Secondary ID:		Asked but unknown _ Medicare #:	
Last Name:				
	First 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	
Transitional ABO / F		- AB+ O- Ansitional ABO / Rh -	O+ Blood type not done Transitional ABO / Transitional Rh	
Group A/Transitional Group	B/ I ransitional	Group O/Transiti	onal Rh Group AB/Transitional Rh	
Patient Medical History				
List the patient's admitting diagnos	is. (Use ICD-10 I	Diagnostic codes/des	criptions)	
Code:	Description:			
Code:	Description:			
	Description:			
List the patient's underlying indicat	ion for transfusio	n. (Use ICD-10 Diagn	ostic 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 57.310 Rev. 3, v9.2

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 H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).



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Code:	Description:	
List the patient's comorbid reaction. (Use ICD-10 Diag	conditions at the time of the transfusion related to the adverse nostic codes/descriptions)	UNKNOWN
Code:	Description:	
Code:	Description:	
Code:	Description:	



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 NONE NONE	ı			
Code: Description:				
Code: Description:				
Code: Description:				
Additional Information				
Transfusion History				
Has the patient received a previous transfusion?				
Blood Product: WB RBC Platelet Plasma Cryoprecipitate Granulocyte	e			
Date of Transfusion:// UNKNOWN				
Was the patient's adverse reaction transfusion-related?				
If yes, provide information about the transfusion adverse reaction.				
Type of transfusion adverse reaction:				
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?	_			
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				
Other signs and symptoms: (check all that apply)				
Generalized: Chills/rigors Fever Nausea/vomiting				
Cardiovascular: Blood pressure decrease Shock				
Cutaneous:				
Other rash Pruritus (itching) Urticaria (hives)				
Hemolysis/Hemorrhage: Disseminated intravascular coagulation Hemoglobinemia				
Pain: Abdominal pain Back pain Flank pain Infusion site pair	1			
Renal: Hematuria Hemoglobinuria Oliguria				
	Bilateral infiltrates on chest x-ray Bronchospasm Cough			
Other: (specify)				

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*Severity	11311
Since this is by definition a reaction with no clinical symptoms, severity of the reaction cannot be graded.	
Not determined	
*Imputability	
Which best describes the relationship between the transfusion and the reaction?	
Transfusion performed by your facility is the only possible cause for seroconversion.	
The patient has other exposures (e.g. transfusion by another facility or pregnancy) that could explain	
seroconversion, but transfusion by your facility is the most likely cause. The patient was transfused by your facility, but other exposures are present that most likely explain	
seroconversion.	
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?	
When was the new alloantibody identified?	
Occurred between 24 hours and 28 days after cessation of transfusion	
Occurred less than 24 hours after cessation of transfusion OR greater than 28 days after cessation of	
transfusion	
No new antibody was identified	
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 <i>imputability</i> designation? YES NO	
^Please indicate your designation	
Patient Treatment	
Did the patient receive treatment for the transfusion reaction?	
If yes, select treatment(s):	
Medication (Select the type of medication)	
	~
Antipyretics Antihistamines Inotropes/Vasopressors Bronchodilator Diuretic	S
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) Page 4 of 6	

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	Hemodialysis	[Peritoneal	Continuous Ven	o-Venous Hem	nofiltration
Phle	ebotomy er Specify:				
Outcome					
*Outcome: Date of		lajor or long-teri /	m sequelae	Minor or no s	equelae 🗌 Not determined
	recipient died, relation	·		Ruled O	ut Not determined
Cause	of death:				
Was ar	n autopsy performed?	Yes	No		
Component					
*Was a partied reaction?	cular unit implicated	d in (i.e., respo	onsible for) the a	dverse	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 ated of unit Unit?
^IMPLICATED	UNIT				
// : //	ISBT-128 Codabar	Entire unit Partial unit mL	 		A- A+ B- B+ AB- AB+
: // : :	ISBT-128	Entire unit Partial unit mL	 	<u> </u>	O- O+ N/A A- A+ B- B+ AB- AB+ O- O+ N/A
Custom Field	ds				
Label			Label		
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Comments					



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