

## Hemovigilance Module Adverse Reaction Delayed 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):

- 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: \_\_\_\_\_

Code: \_\_\_\_\_ Description: \_\_\_\_\_

Code: \_\_\_\_\_ Description: \_\_\_\_\_

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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: \_\_\_\_\_

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  DSTTR  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 (Only answer questions listed under the selected reaction type.)

\* Delayed hemolytic transfusion reaction (DHTR)

Immune Antibody: \_\_\_\_\_  Non-immune (specify) \_\_\_\_\_

#### \*Case Definition

Check the following that occurred between 24 hours and 28 days after cessation of transfusion:

- Positive direct antiglobulin test (DAT)
- Newly-identified red blood cell alloantibody in recipient serum
- Positive elution test with alloantibody present on the transfused red blood cells
- Inadequate rise of post-transfusion hemoglobin level or rapid fall in hemoglobin back to pre-transfusion levels
- Otherwise unexplained appearance of spherocytes

#### Check all that apply:

- Incomplete laboratory evidence
- DHTR is suspected, but reported symptoms, test results, and/or available information are not sufficient

Other signs and symptoms: (check all that apply)

Generalized:	<input type="checkbox"/> Chills/rigors	<input type="checkbox"/> Fever	<input type="checkbox"/> Nausea/vomiting
Cardiovascular:	<input type="checkbox"/> Blood pressure decrease	<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"/> Disseminated intravascular coagulation	<input type="checkbox"/> Hemoglobinemia	

Pain:	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Flank pain	<input type="checkbox"/> Infusion site pain
Renal:	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Hemoglobinuria	<input type="checkbox"/> Oliguria	
Respiratory:	<input type="checkbox"/> Bilateral infiltrates on chest x-ray	<input type="checkbox"/> Bronchospasm	<input type="checkbox"/> Cough	
	<input type="checkbox"/> Hypoxemia	<input type="checkbox"/> Shortness of breath		

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?

- No other explanation for symptoms or newly-identified antibody is present.
- An alternate explanation for symptoms or newly-identified antibody is present, but transfusion is the most likely cause.
- Other explanations for symptoms or newly-identified antibody 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*)
 

<input type="checkbox"/> Antipyretics	<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Inotropes/Vasopressors	<input type="checkbox"/> Bronchodilator	<input type="checkbox"/> Diuretics
<input type="checkbox"/> Intravenous	<input type="checkbox"/> Intravenous steroids	<input type="checkbox"/> Corticosteroids	<input type="checkbox"/> Antibiotics	

**Immunoglobulin**

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?
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**^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
_____ _____ _____	_____ _____ _____

**Comments**

