**Hemovigilance Module**

**Adverse Reaction**

**Allergic 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
|  | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
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|  | | | | 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*** **Allergic reaction, including anaphylaxis** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | **\*Case Definition** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | *Check the following* that occurred during or within **4 hours** of cessation of transfusion: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | Conjunctival edema | | | | | | | | | | | | | | | | | | | | | | Edema of lips, tongue and uvula | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Localized angioedema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Hypotension | | | | | | | | | |
|  | | | | | | | | | | Erythema and edema of the periorbital area | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Respiratory distress; bronchospasm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Urticaria | | | | | | | | | | | | | |
|  | | | | | | | | | | Generalized flushing | | | | | | | | | | | | | | | | | | | | | | | | Maculopapular rash | | | | | | | | | | | | | | | | | | | | | | | | | | | Pruritus | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Other signs and symptoms: (check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Generalized: | | | | | | | | | | | | | | | | | | | | | | | | | Chills/rigors | | | | | | | | | | | | | | | | | | | | | | | | | | | | Fever | | | | | | | | | | | | | | | | | | | | | | | Nausea/vomiting | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Cardiovascular: | | | | | | | | | | | | | | | | | | | | | | | | | Shock | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Cutaneous: | | | | | | | | | | | | | | | | | | | | | | | | | Jaundice | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Hemolysis/Hemorrhage: | | | | | | | | | | | | | | | | | | | | | | | | | Disseminated intravascular coagulation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Hemoglobinemia | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Positive antibody screen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Pain: | | | | | | | | | | | | | | | | | | | | | | | | | Abdominal pain | | | | | | | | | | | | | | | | | | | | | | | | | Back pain | | | | | | | | | | | | | | | | Flank pain | | | | | | | | | | | | | | | | | | | | | | Infusion site pain | | | | | | | | | | | | | | | |
|  | | | | | | Renal: | | | | | | | | | | | | | | | | | | | | | | | | | Hematuria | | | | | | | | | | | | | | | | | | | | | | | | | | | | Hemoglobinuria | | | | | | | | | | | | | | | | | | | | | | | Oliguria | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Respiratory: | | | | | | | | | | | | | | | | | | | | | | | | | Bilateral infiltrates on chest x-ray | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Cough | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Hypoxemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Shortness of breath | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | **\*Imputability** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Which best describes the relationship between the transfusion and the reaction? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | No other evidence of environmental, drug or dietary risks. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | There are other potential causes present that could explain acute hemolysis, but transfusion is the most likely cause. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Other present causes are most 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | Did the transfusion occur at your facility? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | | | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | When did the reaction occur in relation to the transfusion? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Occurred during or within 2 hours of cessation of transfusion. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Occurred 2 - 4 hours after cessation of transfusion. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | Did the same reaction occur after the transfusion was restarted (rechallenge)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | **\*Do you agree with the *case definition* designation?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | | | | | | | | | | | | NO | | | | | | | | |
|  | | | | | | | | **^**Please indicate your designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | **\*Do you agree with the *severity* designation?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | | | | | | | | | | | | NO | | | | | | | | |
|  | | | | | | | | **^**Please indicate your designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | **\*Do you agree with the *imputability* designation?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | | | | | | | | | | | | NO | | | | | | | | |
|  | | | | | | | | **^**Please indicate your designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | Volume resuscitation (Intravenous colloids or crystalloids) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | Respiratory support *(Select the type of support)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | Mechanical ventilation | | | | | | | | | | | | | | | | | | | | | | | | | Noninvasive ventilation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Oxygen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | Renal replacement therapy *(Select the type of therapy)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | Hemodialysis | | | | | | | | | | | | | | | | Peritoneal | | | | | | | | | | | | | | Continuous Veno-Venous Hemofiltration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Component Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*Was a particular unit implicated in (i.e., responsible for) the adverse reaction?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | No | | | | | | | | | N/A | | | |
| Transfusion Startand **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 | | | | | | | | | | | | | | | | | Entire unit  Partial unit  \_\_\_\_\_\_mL | | | | | | | | | | | | | | | | \_\_ \_\_ \_\_ \_\_ \_\_ | | | | | | | | | | | | | | | | | | \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | | | | A- | | | | | | | | A+ | | | | | | | | | | | | B- | | | | Y | |
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| **Custom Fields** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Comments** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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