NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

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www.cdc.gov/nhsn

# 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:** ____/____/_____

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

Sex at Birth: ☐M ☐F ☐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: _____

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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: _____

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) _____

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***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?

- ☐ 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.

Did the transfusion occur at your facility? ☐ YES ☐ NO

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.

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.*

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

## Custom Fields

| Label | | Label | |
|---|---|---|---|
| _____ | _____/_____/_____ | _____ | _____/_____/_____ |
| _____ | _____ | _____ | _____ |

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## Comments