

## Hemovigilance Module Adverse Reaction Transfusion Associated Dyspnea

**\*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

Group B/Transitional

Group O/Transitional Rh

Group AB/Transitional Rh

Rh

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: \_\_\_\_\_

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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: \_\_\_\_\_

## Transfusion Associated Dyspnea

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

\* Transfusion associated dyspnea (TAD)

**\*Case Definition**

**Check all that apply:**

Acute respiratory distress occurring within 24 hours of cessation of transfusion.

Allergic reaction, TACO, and TRALI definitions are not applicable.

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      |   |
|                       | <input type="checkbox"/> Positive antibody screen               |  |   |
| 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?

- Patient has no other conditions that could explain symptoms.
- There are other potential causes that could explain symptoms, 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

**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? |
|-------------------------------------|---|--|---|-----------------------------|--|------------------|
| <b>^IMPLICATED UNIT</b>             |   |  |   |                             |  |                  |
| ____/____/____<br>____:____         | <input type="checkbox"/> ISBT-128<br><input type="checkbox"/> Codabar | <input type="checkbox"/> Entire unit<br><input type="checkbox"/> Partial unit mL | ____-____<br>____-____                          | ____/____/____<br>____:____ | <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B-<br><input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+<br><input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A | Y                |
| ____/____/____<br>____:____         | <input type="checkbox"/> ISBT-128<br><input type="checkbox"/> Codabar | <input type="checkbox"/> Entire unit<br><input type="checkbox"/> Partial unit mL | ____-____<br>____-____                          | ____/____/____<br>____:____ | <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B-<br><input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+<br><input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A | N                |

**Custom Fields**

| Label                   | Label                   |
|-------------------------|-------------------------|
| _____<br>_____<br>_____ | _____<br>_____<br>_____ |

**Comments**