NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

Hemovigilance Module
Adverse Reaction
Transfusion Related Acute Lung Injury

***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): (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 / Transitional Rh ☐ Transitional ABO / Rh + ☐ Transitional ABO / 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: _____

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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: _____

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 related acute lung injury (TRALI)**

	Not Done	Negative	Test result positive: Cognate or cross reacting antigen present	Test result positive: No cognate or cross reacting antigen present	Test result positive: Not tested for cognate antigen
Donor or unit HLA specificity	☐	☐	☐	☐	☐
Donor or unit HNA specificity	☐	☐	☐	☐	☐
Recipient HLA specificity	☐	☐	☐	☐	☐
Recipient HNA specificity	☐	☐	☐	☐	☐

***Case Definition** (*Check all that apply*)

- ☐ NO evidence of acute lung injury (ALI) prior to transfusion.
- ☐ ALI onset during or within 6 hours of cessation of transfusion
- ☐ Hypoxemia – defined as PaO2/FiO2 less than or equal to 300 mm Hg
- ☐ Hypoxemia – defined as Oxygen saturation less than 90% on room air
- ☐ Hypoxemia – defined as Other clinical evidence
- ☐ Radiographic evidence of bilateral infiltrates
- ☐ No evidence of left atrial hypertension (i.e., circulatory overload)

Other signs and symptoms: (check all that apply)

Generalized:	☐ Chills/rigors ☐ Fever ☐ Nausea/vomiting
Cardiovascular:	☐ Blood pressure decrease ☐ Shock
Cutaneous:	☐ Edema ☐ Flushing ☐ Jaundice ☐ Itching ☐ ☐ Other rash

	Hives					
Hemolysis/Hemorrhage:	☐ DIC	☐ Hemoglobinemia	☐ Positive antibody screen			
Pain:	☐ Abdominal pain	☐ Back pain	☐ Flank pain	☐ Infusion site pain		
Renal:	☐ Hematuria	☐ Hemoglobinuria	☐ Oliguria			
Respiratory:	☐ Bronchospasm	☐ Cough	☐ 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

***Imputability**

Which best describes the relationship between the transfusion and the reaction?

☐ There are no alternative risk factors for ALI present.
☐ There is evidence of other causes for acute lung injury.
☐ 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?**
^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	
_____	_____/_____/_____	_____	_____/_____/_____
_____	_____	_____	_____

Comments

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