

Form Approved OMB No. 0920-0666 Exp. Date: 12/31/26 www.cdc.gov/nhsn

Hemovigilance Module Adverse Reaction Other Transfusion Reaction

*Required for saving *Facility ID#: NHSN Adverse Reaction #: **Patient Information** *Patient ID: *Gender: M Other *Date of Birth: / / Gender Identity (Specify): Sex at Birth: M F Unknown Male Female Male-to-female transgender Female-to-male transgender Identifies as non-conforming Other Asked but unknown Secondary ID: _____ Social Security #: _____ Medicare #: _____ Last Name: First Name: ___ Middle Name: Ethnicity (Specify): Race (Specify): (Select all that apply): Hispanic or Latino American Indian or Alaska Native Not Hispanic or Latino Asian Unknown Black or African American Declined to respond Middle Eastern or North African Native Hawaiian or Pacific Islander White Unknown Declined to respond Interpreter Needed: Yes Preferred Language (Specify): Declined to Respond Unknown B-O-*Blood Group: Blood type not done Transitional ABO / Transitional Transitional ABO / Rh + Transitional ABO / Rh -Rh Group B/Transitional Group A/Transitional Group O/Transitional Rh Group AB/Transitional Rh Rh **Patient Medical History** List the patient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions) Description: Code: _____ Description: Code: Description: List the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions) Description: Code:

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)). CDC 57.320 Rev. 3, v9.2

Description:

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).



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Code:	Description:	
	orbid conditions at the time of the transfusion related to the adverse Diagnostic codes/descriptions)	UNKNOWN NONE
Code:	Description:	
Code:	Description:	
Code:	Description:	



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•	nt hospital or outpatient stay. (Use ICD-10	
Code:	Description:	
Code:		
Code:		
Additional Information		
Transfusion History		
Has the patient received a	previous transfusion?	ES NO UNKNOWN
Blood Product:	WB RBC Platelet Plasm	na Cryoprecipitate Granulocyte
Date of Transfusion:	// UNKNOWN	
Was the patient's adverse	e reaction transfusion-related?	YES NO
If yes, provide information	about the transfusion adverse reaction.	
Type of transfusion adver	se reaction: Allergic AHTR	☐ DHTR ☐ DSTR ☐ FNHTR
HTR TTI	PTP TACO TAD TA-	GVHD TRALI UNKNOWN
OTHER Specif	y	
Reaction Details		
*Date reaction occurred:	//_ *Time reaction occurred: _	: Time unknown
*Facility location where pation	ent was transfused:	
Is this reaction associated with	n an incident? Yes No	If Yes, Incident #:
Investigation Results		
Investigation Results * Other		
* Other		
* Other Specify:		
* Other Specify: List tests relevant to react	ion investigation:	
* Other Specify: List tests relevant to react Test name:	ion investigation: Testing date:	Test result:
* Other Specify: List tests relevant to react	ion investigation:	Test result:
* Other Specify: List tests relevant to react Test name:	ion investigation: Testing date: Testing date:	Test result:
* Other Specify: List tests relevant to react Test name: Test name:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Fever	Test result:
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms:	ion investigation: Testing date: Testing date: (check all that apply)	Test result: Test result:
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing	Test result: Test result: Nausea/vomiting Shock Jaundice
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Other rash Pruritus (itchin	Test result: Test result: Nausea/vomiting Shock Jaundice g) Urticaria (hives)
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Other rash Disseminated intravascular coagulations	Test result: Test result: Nausea/vomiting Shock Jaundice g) Urticaria (hives)
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing Other rash Disseminated intravascular coagulation Positive antibody screen	Test result: Test result: Nausea/vomiting Shock Jaundice g) Urticaria (hives) Hemoglobinemia
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage: Pain:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing Other rash Pruritus (itchin Disseminated intravascular coagulati Positive antibody screen Abdominal pain Back pain	Test result: Test result: Nausea/vomiting Shock Jaundice g) Urticaria (hives) on Hemoglobinemia Flank pain Infusion site pain
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing Other rash Pruritus (itchin Disseminated intravascular coagulati Positive antibody screen Abdominal pain Hematuria Hemoglobinuri	Test result: Test result: Nausea/vomiting Shock Jaundice g) Urticaria (hives) on Hemoglobinemia Flank pain Infusion site pain ia Oliguria
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage: Pain:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing Other rash Pruritus (itchin Disseminated intravascular coagulati Positive antibody screen Abdominal pain Back pain Hematuria Hemoglobinuri Bilateral infiltrates on chest x-ray	Test result: Test result: Nausea/vomiting Shock Jaundice g) Urticaria (hives) on Hemoglobinemia Flank pain Infusion site pain ia Oliguria Bronchospasm Cough
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage: Pain: Renal:	ion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing Other rash Pruritus (itchin Disseminated intravascular coagulati Positive antibody screen Abdominal pain Hematuria Hemoglobinuri	Test result: Test result: Nausea/vomiting Shock Jaundice g) Urticaria (hives) on Hemoglobinemia Flank pain Infusion site pain ia Oliguria Bronchospasm Cough





*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?		
Conclusive evidence exists that the adverse reaction can be attributed to the transfusion.		
Evidence is clearly in favor of attributing the adverse reaction to the transfusion.		
Evidence is indeterminate for attributing the adverse reaction to the transfusion or an alternate cause.		
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 <u>case definition</u> designation?		
^Please indicate your designation		
*Do you agree with the <u>severity</u> designation?		
^Please indicate your designation		
*Do you agree with the <i>imputability</i> designation?		
^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		
Antithymocyte globulin Cyclosporin Other		
Volume resuscitation (Intravenous colloids or crystalloids)		
Respiratory support (Select the type of support)		
Mechanical ventilation Noninvasive ventilation Oxygen		
<u> </u>		



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Renal replacement therapy (Select the type of therapy)						
Hemodialysis Peritoneal Continuous Veno-Venous Hemofiltration						
	ebotomy					
Othe	er Specify:					
Outcome						
*Outcome:		ajor or long-terr	m sequelae se	Minor or no equelae	Not deter	mined
Date of		/				
	ecipient died, relation	· —				
	Definite Probabl	e Possib	le Doubtful	Ruled Ou	t Not determin	ed
	of death:					
was an	autopsy performed?	Yes	No No			
Component				_		
*Was a partic	cular unit implicate	d in (i.e., respo		dverse	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	Implic ated Unit?
^IMPLICATED UNIT						
	ISBT-128					
:	Codabar	Entire unit		, ,	A- A+ B-	
		Partial unit				Y
/		mL			B+ AB- AB+	
:				::	O- O+ N/A	
	SBT-128					
:	Codabar	Entire unit			A- A+ B-	N
, ,		Partial unit mL			B+ AB- AB+	
					O- O+ N/A	
Custom Field	ds			·		
Label			Label			
		' /	Laber		1 1	
Comments						



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