

Hemovigilance Module Adverse Reaction Transfusion Associated Circulatory Overload

***Required for saving**

*Facility ID#: _____ NHSN Adverse Reaction #: _____

Patient Information

| | | | |
|--|--|--|---|
| *Patient ID: _____ | | *Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other | *Date of Birth: ____/____/____ |
| Sex at Birth: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Declined to Respond <input type="checkbox"/> Unknown | |
| *Blood Group: <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B- <input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+ <input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> Blood type not done | | | |
| <input type="checkbox"/> Transitional ABO / Rh + <input type="checkbox"/> Transitional ABO / Rh - <input type="checkbox"/> Transitional ABO / Transitional Rh | | | |
| <input type="checkbox"/> Group A/Transitional Rh | <input type="checkbox"/> Group B/Transitional Rh | <input type="checkbox"/> Group O/Transitional Rh | <input type="checkbox"/> 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: _____ |
|-------------|--------------------|

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 57.318 Rev. 3, v9.2

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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 DSTTR 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 circulatory overload (TACO)**

*Case Definition

Check all that occurred within 12 hours of cessation of transfusion (new onset or exacerbation):

Acute respiratory distress (dyspnea, orthopnea, cough)

Elevated brain natriuretic peptide (BNP)

Elevated central venous pressure (CVP)

Evidence of left heart failure

Evidence of positive fluid balance

Radiographic evidence of pulmonary edema

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?

- No other explanations for circulatory overload are possible.
- Transfusion is a likely contributor to circulatory overload
- The patient has a history of a pre-existing condition(s) that most likely explains circulatory overload.
- 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

Does the patient have a history of cardiac insufficiency?

- Yes, the patient has a history of cardiac insufficiency that could explain the circulatory overload, but transfusion is just as likely to have caused the circulatory overload.
- Yes, the patient has a history of pre-existing cardiac insufficiency that most likely explains circulatory overload.
- No, the patient does not have a history of cardiac insufficiency.

Did the patient received other fluids in addition to the transfusion? 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? |
|--|--|--|---|----------------------------------|--|------------------|
| ____/____/____ ____:____:____ ____/____/____ | <input type="checkbox"/> ISBT-128 <input type="checkbox"/> Codabar _____ | <input type="checkbox"/> Entire unit <input type="checkbox"/> Partial unit mL _____ | _____ _____ _____ | ____/____/____ ____:____:____ | <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B- <input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+ | Y |

| | | | | | | | | |
|----------------------|-----------------------------------|--|-------|-----------------------------|-----------------------------|------------------------------|------------------------------|---|
| : | | | | | <input type="checkbox"/> O- | <input type="checkbox"/> O+ | <input type="checkbox"/> N/A | |
| ____/____/____ | <input type="checkbox"/> ISBT-128 | <input type="checkbox"/> Entire unit <input type="checkbox"/> Partial unit _____mL | _____ | ____/____/____ | <input type="checkbox"/> A- | <input type="checkbox"/> A+ | <input type="checkbox"/> B- | N |
| ____:____ | <input type="checkbox"/> Codabar | | _____ | _____ | <input type="checkbox"/> B+ | <input type="checkbox"/> AB- | <input type="checkbox"/> AB+ | |
| ____/____/____ | _____ | _____ | _____ | <input type="checkbox"/> O- | <input type="checkbox"/> O+ | <input type="checkbox"/> N/A | | |
| ____: | | | | | | | | |
| Custom Fields | | | | | | | | |
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| Comments | | | | | | | | |
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