

## Hemovigilance Module Adverse Reaction Infection

**\*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 \_\_\_\_\_

Interpreter Needed:  Yes  No

Declined to Respond Unknown

Preferred Language (Specify): \_\_\_\_\_

\*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: \_\_\_\_\_

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: \_\_\_\_\_

## Infection

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**

\* Infection

**\*Case Definition**

Was a test to detect a specific pathogen performed on the recipient post-transfusion?  Yes  No  
 If Yes, positive or reactive results?  Yes  No  
 Org1 \_\_\_\_\_ Org2 \_\_\_\_\_ Org3 \_\_\_\_\_

Was a test to detect a specific pathogen performed on the donor post-donation?  Yes  No  
 If Yes, positive or reactive results?  Yes  No  
 Org1 \_\_\_\_\_ Org2 \_\_\_\_\_ Org3 \_\_\_\_\_

Was a test to detect a specific pathogen performed on the unit post-transfusion? (i.e., culture, serology, NAT)  Yes  No  
 If Yes, positive or reactive results?  Yes  No  
 Org1 \_\_\_\_\_ Org2 \_\_\_\_\_ Org3 \_\_\_\_\_

Check all that apply:  
 Temporally associated unexplained clinical illness consistent with infection

Other signs and symptoms: (check all that apply)

**Generalized:**  Chills/rigors  Fever  Nausea/vomiting

<b>Cardiovascular:</b>	<input type="checkbox"/> Blood pressure decrease	<input type="checkbox"/> Shock		
<b>Cutaneous:</b>	<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)	
<b>Hemolysis/Hemorrhage:</b>	<input type="checkbox"/> Disseminated intravascular coagulation		<input type="checkbox"/> Hemoglobinemia	
	<input type="checkbox"/> Positive antibody screen			
<b>Pain:</b>	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Flank pain	<input type="checkbox"/> Infusion site pain
<b>Renal:</b>	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Hemoglobinuria	<input type="checkbox"/> Oliguria	
<b>Respiratory:</b>	<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		
<input type="checkbox"/> 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 potential exposures to the pathogen could be identified in the recipient.
- Evidence is clearly in favor of a cause other than 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.

Check all that apply:

- Evidence of the pathogen in the transfused component.
- Evidence of the pathogen in the donor at the time of donation.
- Evidence of the pathogen in an additional component from the same donation.
- Evidence of the pathogen in an additional recipient of a component from the same donation.
- Evidence that the identified pathogen strains are related by molecular or extended phenotypic comparison testing with statistical confidence ( $p < 0.05$ ).
- Evidence that the transfused component was negative for this pathogen at the time of transfusion
- Evidence that the donor was negative for this pathogen at the time of donation.
- Evidence that additional components from the same donation were negative for this pathogen.
- Evidence that the recipient was not infected with the pathogen prior to transfusion.
- Laboratory evidence that the recipient was infected with this pathogen prior to transfusion.

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?
____/____/____ ____:____:____	<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+ <input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A	Y
____/____/____ ____:____:____	<input type="checkbox"/> ISBT-128	<input type="checkbox"/> Entire unit	____-____-____ ____-____-____	____/____/____ ____:____:____	<input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B-	N

_____ : _____ _____ / _____ / _____ _____ : _____	<input type="checkbox"/> Codabar _____	<input type="checkbox"/> Partial unit _____ mL _____	_____ : _____	<input type="checkbox"/> B+ <input type="checkbox"/> O-	<input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> AB+ <input type="checkbox"/> N/A	
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**Custom Fields**

Label	Label
_____ / _____ / _____	_____ / _____ / _____
_____	_____

**Comments**