

## 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 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: \_\_\_\_\_

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 57.315 Rev. 3, v9.2

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).

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>						
____/____/____ ____:____:____	<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"/> 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	N

**Custom Fields**

Label	Label
_____ _____ _____	_____ _____ _____

**Comments**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_