

Hemovigilance Module Adverse Reaction Transfusion Related Acute Lung Injury

***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): (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 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"/> 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: _____
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 57.317 Rev. 3, v9.2

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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	No cognate or cross reacting antigen present	Not tested for cognate antigen
Donor or unit HLA specificity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Donor or unit HNA specificity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recipient HLA specificity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recipient HNA specificity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- *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:	<input type="checkbox"/> DIC	<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"/> Bronchospasm	<input type="checkbox"/> Cough	<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?

- 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						
____/____/____ ____:____	<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
