

## Hemovigilance Module

### Adverse Reaction

### Transfusion Associated Dyspnea

**\*Required for saving**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| *Facility ID#: _____ NHSN Adverse Reaction #: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       |
| <b>Patient Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                       |
| *Patient ID: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | *Date of Birth: ____/____/____        |
| *Sex: <input type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |
| Social Security #: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Secondary ID: _____ Medicare #: _____ |
| Last Name: _____ First Name: _____ Middle Name: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       |
| Ethnicity (Specify): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to respond                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                       |
| Race (Select all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to respond                                                                                                                                                                                                                          |                                       |
| Preferred Language (Specify from the list provided): _____ Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Respond                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       |
| *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<br><input type="checkbox"/> Transitional ABO / Rh + <input type="checkbox"/> Transitional ABO / Rh - <input type="checkbox"/> Rh<br><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 |                                       |
| <b>Patient Medical History</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                       |
| 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: _____                    |
| 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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |
| 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: \_\_\_\_\_

## 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*)
- |                                                     |                                               |                                                 |                                         |                                    |
|-----------------------------------------------------|-----------------------------------------------|-------------------------------------------------|-----------------------------------------|------------------------------------|
| <input type="checkbox"/> Antipyretics               | <input type="checkbox"/> Antihistamines       | <input type="checkbox"/> Inotropes/Vasopressors | <input type="checkbox"/> Bronchodilator | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> Intravenous Immunoglobulin | <input type="checkbox"/> Intravenous steroids | <input type="checkbox"/> Corticosteroids        | <input type="checkbox"/> Antibiotics    |                                    |
| <input type="checkbox"/> Antithymocyte globulin     | <input type="checkbox"/> Cyclosporin          | <input type="checkbox"/> Other                  |                                         |                                    |
- ☐ Volume resuscitation (Intravenous colloids or crystalloids)
- ☐ Respiratory support (*Select the type of support*)
- |                                                 |                                                  |                                 |
|-------------------------------------------------|--------------------------------------------------|---------------------------------|
| <input type="checkbox"/> Mechanical ventilation | <input type="checkbox"/> Noninvasive ventilation | <input type="checkbox"/> 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>             |                                                                       |                                                                                  |                                                 |                                  |                                                                                                                                                                                                                                                                      |                  |
| ____/____/____<br>____:____:____    | <input type="checkbox"/> ISBT-128<br><input type="checkbox"/> Codabar | <input type="checkbox"/> Entire unit<br><input type="checkbox"/> Partial unit mL | _____<br>_____<br>_____                         | ____/____/____<br>____:____:____ | <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B-<br><input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+<br><input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A | Y                |
| ____/____/____<br>____:____:____    | <input type="checkbox"/> ISBT-128<br><input type="checkbox"/> Codabar | <input type="checkbox"/> Entire unit<br><input type="checkbox"/> Partial unit mL | _____<br>_____<br>_____                         | ____/____/____<br>____:____:____ | <input type="checkbox"/> A- <input type="checkbox"/> A+ <input type="checkbox"/> B-<br><input type="checkbox"/> B+ <input type="checkbox"/> AB- <input type="checkbox"/> AB+<br><input type="checkbox"/> O- <input type="checkbox"/> O+ <input type="checkbox"/> N/A | N                |

## Custom Fields

| Label                   | Label                   |
|-------------------------|-------------------------|
| _____<br>_____<br>_____ | _____<br>_____<br>_____ |

## Comments