

Hemovigilance Module Adverse Reaction Delayed Serologic Transfusion Reaction

*Required for saving NHSN Adverse Reaction #: *Facility ID#: **Patient Information *Date of Birth:** /___/___ *Patient ID: *Sex: M F Medicare #: Social Security #: Secondary ID: Last Name: First Name: Middle Name: Ethnicity (Specify): Hispanic or Latino Not Hispanic or Latino Unknown Declined to respond Black or African American Indian or Asian Middle Eastern or North Race (Select all that Alaska Native American African Native Hawaiian or White apply): Unknown Declined to respond Pacific Islander Interpreter Needed: Yes No Preferred Language (Specify from the list provided): Unknow Declined to Respond *Blood Group: | A- A+ | B- | B+ | AB-AB+ 0-O+ Blood type not done Transitional ABO / Rh + Transitional ABO / Rh -Transitional ABO / Transitional Rh Group A/Transitional Group B/Transitional Group O/Transitional Rh Group AB/Transitional Rh Rh **Patient Medical History** List the patient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions) Description: Code: _____ Description: Code: Description: List the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions) Code: _____ Code: Description: Code: Description: **UNKNOWN** List the patient's comorbid conditions at the time of the transfusion related to the adverse reaction. (Use ICD-10 Diagnostic codes/descriptions) NONE Code: Description: Code: _____ Description: Code:

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 57.310 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).





	edical procedure including past procedures and procedures to be Link UNKNOWN thospital or outpatient stay. (Use ICD-10 Procedure NONE								
Code:	Description:								
Code:	Description:								
Code:	Description:								
Additional Information									
Transfusion History									
Has the patient received a p	revious transfusion? YES NO UNKNOWN								
Blood Product:	WB RBC Platelet Plasma Cryoprecipitate Granulocyte								
Date of Transfusion:// UNKNOWN									
Was the patient's adverse reaction transfusion-related?									
If yes, provide information about the transfusion adverse reaction.									
Type of transfusion adverse reaction: Allergic AHTR DHTR DSTR FNHTR									
HTR TII PTP TACO TAD TA-GVHD TRALI UNKNOWN									
OTHER Specify									
Reaction Details									
*Date reaction occurred:/	/ *Time reaction occurred:: Time unknown								
*Facility location where patie	*Facility location where patient was transfused:								
Is this reaction associated with	an incident? Yes No If Yes, Incident #:								
Investigation Results									
Investigation Results									
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*Severity									
Since this is by definition a reaction with no clinical symptoms, severity of the reaction cannot be graded.									
Not determined									
*Imputability									
Which best describes the relationship between the transfusion and the reaction?									
Transfusion performed by your facility is the only possible cause for seroconversion.									
The patient has other exposures (e.g. transfusion by another facility or pregnancy) that could explain seroconversion, but transfusion by your facility is the most likely cause.									
The patient was transfused by your facility, but other exposures are present that most likely explain									
seroconversion.									
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?									
When was the new alloantibody identified?									
Occurred between 24 hours and 28 days after cessation of transfusion									
Occurred less than 24 hours after cessation of transfusion OR greater than 28 days after cessation of									
transfusion No new antibody was identified									
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 <u>case definition</u> designation?									
^Please indicate your designation									
*Do you agree with the <u>severity</u> designation?									
^Please indicate your designation									
*Do you agree with the <i>imputability</i> designation?									
^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)									
Incarcation (General trie 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)									



Continuous Veno-Venous Hemofiltration Hemodialysis Peritoneal												
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?												
Transfusion Start and End Date/Time	*Component code (check system used)	Amount transfused at reaction onset	(Requ	number lired for on and I)	*Unit expiration Date/Time		*Blood group of unit		Implic ated Unit?			
^IMPLICATED UNIT												
1 1	ISBT-128											
	Codabar	Entire unit			1 1		A- A+	В-				
1 1		Partial unit mL					B+ AB-	AB+	Y			
					:		O- O+	N/A				
	ISBT-128											
:	Codabar	Entire unit					A- A+	B-	N			
1 1		Partial unitmL					B+ AB-	AB+	"			
::					::		O- O+	N/A				
Custom Field	ds											
Label				Label								
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Comments												

