Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2027
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Hemovigilance Module
Adverse Reaction
Delayed Serologic Transfusion Reaction

***Required for saving**

*Facility ID#: _____ NHSN Adverse Reaction #: _____

Patient Information

***Patient ID:** _____ ***Date of Birth:** ___/___/____

***Sex:** ☐ M ☐ F

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 (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 from the list provided):_____ Interpreter Needed: ☐ Yes ☐ No ☐ Unknown ☐ Declined to Respond

***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: _____

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: _____

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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

*☐ **Delayed serologic transfusion reaction (DSTR)**

Antibody(ies): _____

***Case Definition** **Check all that apply:**

- ☐ Absence of clinical signs of hemolysis
- ☐ Positive direct antiglobulin test (DAT)
- ☐ Demonstration of new, clinically-significant antibodies against red blood cells
- ☐ Positive antibody screen with newly identified RBC alloantibody

Other signs and symptoms: (check all that apply)

Generalized:	☐ Chills/rigors	☐ Fever	☐ Nausea/vomiting
Cardiovascular:	☐ Blood pressure decrease	☐ Shock	
Cutaneous:	☐ Edema	☐ Flushing	☐ Jaundice
	☐ Other rash	☐ Pruritus (itching)	☐ Urticaria (hives)
Hemolysis/Hemorrhage:	☐ Disseminated intravascular coagulation	☐ Hemoglobinemia	
Pain:	☐ Abdominal pain	☐ Back pain	☐ Flank pain ☐ Infusion site pain
Renal:	☐ Hematuria	☐ Hemoglobinuria	☐ Oliguria
Respiratory:	☐ Bilateral infiltrates on chest x-ray	☐ Bronchospasm	☐ Cough
	☐ Hypoxemia	☐ Shortness of breath	

☐ Other: (specify) _____

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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? ☐ YES ☐ NO

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 *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)*

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☐ 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?** ☐ 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								
___/___/___ ___ ___:___ ___/___/___ ___ ___:___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _____	☐ Entire unit ☐ Partial unit _____mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____:_____	☐ A- ☐ B+ ☐ O-	☐ A+ ☐ AB- ☐ O+	☐ B- ☐ AB+ ☐ N/A	Y
___/___/___ ___ ___:___ ___/___/___ ___ ___:___	☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _____	☐ Entire unit ☐ Partial unit _____mL	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	___/___/_____ _____:_____	☐ A- ☐ B+ ☐ O-	☐ A+ ☐ AB- ☐ O+	☐ B- ☐ AB+ ☐ N/A	N

Custom Fields

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

Comments

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