

Hemovigilance Module

Adverse Reaction

Other Transfusion Reaction

***Required for saving**

*Facility ID#: _____		NHSN Adverse Reaction #: _____	
Patient Information			
*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 <input type="checkbox"/> Transitional ABO / Transitional Rh <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. <i>(Use ICD-10 Diagnostic codes/descriptions)</i>			
Code: _____		Description: _____	
Code: _____		Description: _____	
Code: _____		Description: _____	
List the patient's underlying indication for transfusion. <i>(Use ICD-10 Diagnostic codes/descriptions)</i>			
Code: _____		Description: _____	
Code: _____		Description: _____	
Code: _____		Description: _____	
List the patient's comorbid conditions at the time of the transfusion related to the adverse reaction. <i>(Use ICD-10 Diagnostic codes/descriptions)</i>			<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NONE
Code: _____		Description: _____	
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 57.320 Rev. 3, v9.2

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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 ☐ DSTTR ☐ 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

*☐ Other
 Specify: _____

List tests relevant to reaction investigation:

Test name: _____ Testing date: _____ Test result: _____
 Test name: _____ Testing date: _____ Test result: _____

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?

- ☐ Conclusive evidence exists that the adverse reaction can be attributed to the transfusion.
- ☐ Evidence is clearly in favor of attributing the adverse reaction to the transfusion.
- ☐ Evidence is indeterminate for attributing the adverse reaction to the transfusion or an alternate cause.
- ☐ 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?
____/____/____ ____:____	<input type="checkbox"/> IGBT-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"/> IGBT-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

