

Hemovigilance Module Adverse Reaction Transfusion Associated Circulatory Overload

***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 / Rh + <input type="checkbox"/> Transitional ABO / Rh - <input type="checkbox"/> Transitional ABO / Transitional 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: _____	
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)			<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 57.318 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 ☐ 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 circulatory overload (TACO)

*Case Definition

Check all that occurred within 12 hours of cessation of transfusion (new onset or exacerbation):

☐ Acute respiratory distress (dyspnea, orthopnea, cough)

☐ Elevated brain natriuretic peptide (BNP)

☐ Elevated central venous pressure (CVP)

☐ Evidence of left heart failure

☐ Evidence of positive fluid balance

☐ Radiographic evidence of pulmonary edema

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:	<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"/> Hypoxemia	<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?

- ☐ No other explanations for circulatory overload are possible.
- ☐ Transfusion is a likely contributor to circulatory overload
- ☐ The patient has a history of a pre-existing condition(s) that most likely explains circulatory overload.
- ☐ 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

Does the patient have a history of cardiac insufficiency?

- ☐ Yes, the patient has a history of cardiac insufficiency that could explain the circulatory overload, but transfusion is just as likely to have caused the circulatory overload.
- ☐ Yes, the patient has a history of pre-existing cardiac insufficiency that most likely explains circulatory overload.
- ☐ No, the patient does not have a history of cardiac insufficiency.

Did the patient received other fluids in addition to the transfusion? ☐ 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?
____/____/____ ____:____:____	<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
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Comments	
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