

## Hemovigilance Module Adverse Reaction Unknown Transfusion Reaction

\*Required for saving

\*Facility ID#: \_\_\_\_\_ NHSN Adverse Reaction #: \_\_\_\_\_

### Patient Information

\*Patient ID: \_\_\_\_\_ \*Gender:  M  F  Other \*Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security #: \_\_\_\_\_ Secondary ID: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Ethnicity  Hispanic or Latino  Not Hispanic or Not Latino  
 Race  American Indian/Alaska Native  Asian  Black or African American  
 Native Hawaiian/Other Pacific Islander  White  
 \*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

\* **Unknown**  
Diagnosis of case: \_\_\_\_\_

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*)
  - 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						
<b>*Outcome:</b> <input type="checkbox"/> Death <input type="checkbox"/> Major or long-term sequelae <input type="checkbox"/> Minor or no sequelae <input type="checkbox"/> Not determined Date of Death:     ___ / ___ / ___ ^If recipient died, relationship of transfusion to death: <input type="checkbox"/> Definite <input type="checkbox"/> Probable <input type="checkbox"/> Possible <input type="checkbox"/> Doubtful <input type="checkbox"/> Ruled Out <input type="checkbox"/> Not determined Cause of death:     _____ Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Component Details						
<b>*Was a particular unit implicated in (i.e., responsible for) the adverse reaction?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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						
___ / ___ / ___ :___	<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	<b>Y</b>
___ / ___ / ___ :___	<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	<b>N</b>
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