Form Approved
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www.cdc.gov/nhsn

National Healthcare Safety Network

Hemovigilance Module
Adverse Reaction
Delayed Serologic 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 #: __________
First Name: __________ Middle Name: __________
Last 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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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,
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306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for
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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 D-74,
Atlanta, GA 30333 ATTN: PRA (0920-0666).
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)*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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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)

<table>
<thead>
<tr>
<th>Generalized:</th>
<th>Chills/rigors</th>
<th>Fever</th>
<th>Nausea/vomiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular:</td>
<td>Blood pressure decrease</td>
<td>Shock</td>
<td></td>
</tr>
<tr>
<td>Cutaneous:</td>
<td>Edema</td>
<td>Flushing</td>
<td>Jaundice</td>
</tr>
<tr>
<td>Other rash</td>
<td>Pruritus (itching)</td>
<td>Urticaria (hives)</td>
<td></td>
</tr>
<tr>
<td>Hemolysis/Hemorrhage:</td>
<td>Disseminated intravascular coagulation</td>
<td>Hemoglobinemia</td>
<td></td>
</tr>
<tr>
<td>Pain:</td>
<td>Abdominal pain</td>
<td>Back pain</td>
<td>Flank pain</td>
</tr>
<tr>
<td>Renal:</td>
<td>Hematuria</td>
<td>Hemoglobinuria</td>
<td>Oliguria</td>
</tr>
<tr>
<td>Respiratory:</td>
<td>Bilateral infiltrates on chest x-ray</td>
<td>Bronchospasm</td>
<td>Cough</td>
</tr>
</tbody>
</table>

☐ Other: (specify)  

☐ Other: ________________________________
**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

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**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)
  - Antipyractics
  - 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
**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

<table>
<thead>
<tr>
<th>Transfusion Start and End Date/Time</th>
<th><em>Component code</em> (check system used)</th>
<th>Amount transfused at reaction onset</th>
<th>^Unit number (Required for Infection and TRALI)</th>
<th>^Unit expiration Date/Time</th>
<th>*Blood group of unit</th>
<th>Implicated Unit?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>ISBT-128</td>
<td>Entire unit</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Codabar</td>
<td>Partial unit mL</td>
<td></td>
<td></td>
<td></td>
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**Custom Fields**

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