



Hemovigilance Module Adverse Reaction Transfusion Associated Dyspnea

*Required for saving

*Facility ID#: _____ NHSN Adverse Reaction #: _____	
Patient Information	
*Patient ID: _____	*Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Social Security #: _____	*Date of Birth: ____/____/____
Last Name: _____	Secondary ID: _____ Medicare #: _____
First Name: _____	Middle Name: _____
Ethnicity <input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Not Latino
Race <input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White
*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. <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)).	
Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the 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).	

Transfusion Associated Dyspnea

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 dyspnea (TAD)**

***Case Definition**

Check all that apply:

Acute respiratory distress occurring within 24 hours of cessation of transfusion.

Allergic reaction, TACO, and TRALI definitions are not applicable.

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?

- Patient has no other conditions that could explain symptoms.
- There are other potential causes that could explain symptoms, but transfusion is the most likely cause.
- Other present causes are most likely, but transfusion cannot be ruled out.
- 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

*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

____/____/____ ____:____	<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
_____ _____ _____	_____ _____ _____

Comments

