

Hemovigilance Module

Adverse Reaction

Delayed Hemolytic Transfusion Reaction

***Required for saving**

*Facility ID#: _____		NHSN Adverse Reaction #: _____	
Patient Information			
*Patient ID: _____		*Date of Birth: ____/____/____	
*Sex: ☐ M ☐ F			
Social Security #: _____		Secondary ID: _____ Medicare #: _____	
Last Name: _____		First Name: _____ Middle Name: _____	
Ethnicity (Specify): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declined to respond			
Race (Select all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown ☐ Declined to respond			
Preferred Language (Specify from the list provided): _____		Interpreter Needed: ☐ Yes ☐ No ☐ Declined to Respond ☐ Unknown	
*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. <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>			☐ UNKNOWN ☐ 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 57.309 Rev. 3, v9.2

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 H21-8, 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) ☐ 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 (Only answer questions listed under the selected reaction type.)

*☐ Delayed hemolytic transfusion reaction (DHTR)

☐ Immune Antibody: _____ ☐ Non-immune (specify) _____

*Case Definition

Check the following that occurred **between 24 hours and 28 days** after cessation of transfusion:

- ☐ Positive direct antiglobulin test (DAT)
- ☐ Newly-identified red blood cell alloantibody in recipient serum
- ☐ Positive elution test with alloantibody present on the transfused red blood cells
- ☐ Inadequate rise of post-transfusion hemoglobin level or rapid fall in hemoglobin back to pre-transfusion levels
- ☐ Otherwise unexplained appearance of spherocytes

Check all that apply:

- ☐ Incomplete laboratory evidence
- ☐ DHTR is suspected, but reported symptoms, test results, and/or available information are not sufficient

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:	☐ Disseminated intravascular coagulation	☐ Hemoglobinemia	
Pain:	☐ Abdominal pain	☐ Back pain	☐ Flank pain
			☐ Infusion site pain

Renal:	☐ Hematuria	☐ Hemoglobinuria	☐ Oliguria
Respiratory:	☐ Bilateral infiltrates on chest x-ray	☐ Bronchospasm	☐ Cough
	☐ Hypoxemia	☐ Shortness of breath	
☐ Other: (specify) _____			

***Severity**

Did the patient receive or experience any of the following?

- | | |
|---|---|
| ☐ No treatment required | ☐ Symptomatic treatment only |
| ☐ Hospitalization, including prolonged hospitalization | ☐ Life-threatening reaction |
| ☐ Disability and/or incapacitation | ☐ Congenital anomaly or birth defect(s) of the fetus |
| ☐ Other medically important conditions | ☐ Death ☐ Unknown or not stated |

***Imputability**

Which best describes the relationship between the transfusion and the reaction?

- ☐ No other explanation for symptoms or newly-identified antibody is present.
- ☐ An alternate explanation for symptoms or newly-identified antibody is present, but transfusion is the most likely cause.
- ☐ Other explanations for symptoms or newly-identified antibody are more 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						
____/____/____ ____:____ ____/____/____ :	☐ ISBT-128 ☐ Codabar _____	☐ Entire unit ☐ Partial unit _____ mL	_____ _____ _____	____/____/____ :	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	Y
____/____/____ ____:____ ____/____/____ :	☐ ISBT-128 ☐ Codabar _____	☐ Entire unit ☐ Partial unit _____ mL	_____ _____ _____	____/____/____ :	☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A	N

Custom Fields

Label	Label
_____ _____ _____/____/____	_____ _____ _____/____/____

Comments