



Hemovigilance Module Adverse Reaction Acute Hemolytic 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

Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.)

(part 1) List the patient's admitting diagnosis. (Use ICD-10 Diagnostic codes/descriptions)

Code: _____ Description: _____
 Code: _____ Description: _____
 Code: _____ Description: _____

(part 2) List the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions)

Code: _____ Description: _____
 Code: _____ Description: _____
 Code: _____ Description: _____

(part 3) 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: _____

Continued >>

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Acute Hemolytic Transfusion Reaction

Patient Medical History (Use worksheet on page 4 for additional codes and descriptions.)	
<p>(part 4) 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)</p> <p>Code: _____ Description: _____</p> <p>Code: _____ Description: _____</p> <p>Code: _____ Description: _____</p>	<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NONE
<p>(part 5) Additional Information _____</p> <p>_____</p> <p>_____</p>	

Transfusion History (Use worksheet on page 4 for additional transfusion history.)
<p>*Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN</p> <p>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Was the patient's adverse reaction transfusion-related? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTRT <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>

Reaction Details
<p>*Date reaction occurred: ___/___/___ *Time reaction occurred: ___:___ <input type="checkbox"/> Time unknown</p> <p>*Facility location where patient was transfused: _____</p> <p>*Is this reaction associated with an incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Incident #: _____</p> <p>After recognition of the transfusion reaction, was the current transfusion:</p> <p><input type="checkbox"/> Continued <input type="checkbox"/> Stopped and restarted <input type="checkbox"/> Stopped indefinitely</p>

Investigation Results
<p>*<input type="checkbox"/> Acute hemolytic transfusion reaction (AHTR)</p> <p><input type="checkbox"/> Immune Antibody: _____ <input type="checkbox"/> Non-immune (specify) _____</p>
<p>*Case Definition</p> <p>Check the following that occurred during, or within 24 hours of cessation of transfusion with new onset:</p> <p><input type="checkbox"/> Back/flank pain <input type="checkbox"/> Chills/rigors <input type="checkbox"/> Epistaxis <input type="checkbox"/> Disseminated intravascular coagulation (DIC)</p> <p><input type="checkbox"/> Oliguria/anuria <input type="checkbox"/> Hypotension <input type="checkbox"/> Fever <input type="checkbox"/> Hematuria (gross visual hemolysis)</p> <p><input type="checkbox"/> Pain and/or oozing at IV site <input type="checkbox"/> Renal failure <input type="checkbox"/> None of the above</p> <p style="text-align: right;"><i>Continued >></i></p>

Acute Hemolytic Transfusion Reaction

Investigation Results (continued)

- Check all that apply: Decreased fibrinogen Decreased haptoglobin Elevated bilirubin
- Elevated LDH Hemoglobinemia Hemoglobinuria Plasma discoloration c/w hemolysis
- Spherocytes on blood film Positive direct antiglobulin test (DAT) for anti-IgG or anti-C3
- Positive elution test with alloantibody present on the transfused red blood cells
- Serologic testing is negative, and physical cause (e.g., thermal, osmotic, mechanical, chemical) is confirmed.
- Physical cause is excluded but serologic evidence is not sufficient to meet definitive criteria.
- Physical cause is suspected and serologic testing is negative.
- AHTR is suspected, but symptoms, test results, and/or information are not sufficient to confirm reaction.

Other signs and symptoms: (check all that apply)

Generalized:	<input type="checkbox"/> Nausea/vomiting
Cardiovascular:	<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"/> Hemoglobinemia <input type="checkbox"/> Positive antibody screen
Pain:	<input type="checkbox"/> Abdominal pain
Respiratory:	<input type="checkbox"/> Bilateral infiltrates on chest x-ray <input type="checkbox"/> Bronchospasm <input type="checkbox"/> Cough
	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Hypoxemia
<input type="checkbox"/> Other: (specify) _____	

***Severity**

Did the patient receive or experience any of the following? (Response definitions listed in the protocol)

- Symptomatic treatment only Hospitalization, including prolonged hospitalization
- Life-threatening reaction Disability and/or incapacitation
- Congenital anomaly or birth defect(s) of the fetus Death
- Other medically important conditions Unknown or not stated

***Imputability**

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

- ABO or other allotypic RBC antigen incompatibility is known.
- Only transfusion-related (i.e., immune or non-immune) cause of acute hemolysis is present.
- There are other potential causes present that could explain acute hemolysis, but transfusion is the most likely 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

Continued >>

Acute Hemolytic Transfusion Reaction

Investigation Results (continued)	
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Please indicate your designation _____	
Do you agree with the severity designation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Please indicate your designation _____	
Do you agree with the imputability designation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Please indicate your designation _____	
Additional Information _____ _____ _____	
Patient Treatment	
*Did the patient receive treatment for the transfusion reaction?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
If yes, select treatment(s):	
<input type="checkbox"/> Medication (Select the type of medication)	
<input type="checkbox"/> Antipyretics <input type="checkbox"/> Antihistamines <input type="checkbox"/> Inotropes/Vasopressors <input type="checkbox"/> Bronchodilator <input type="checkbox"/> Diuretics <input type="checkbox"/> Intravenous Immunoglobulin <input type="checkbox"/> Intravenous steroids <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Antithymocyte globulin <input type="checkbox"/> Cyclosporin <input type="checkbox"/> H1 receptor blockers <input type="checkbox"/> Other	
<input type="checkbox"/> Volume resuscitation (Intravenous colloids or crystalloids)	
<input type="checkbox"/> Respiratory support (Select the type of support)	
<input type="checkbox"/> Mechanical ventilation <input type="checkbox"/> Noninvasive ventilation <input type="checkbox"/> Oxygen	
<input type="checkbox"/> Renal replacement therapy (Select the type of therapy)	
<input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Continuous Veno-Venous Hemofiltration	
<input type="checkbox"/> Phlebotomy	
<input type="checkbox"/> Other Specify: _____	
Outcome	
*Outcome: <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	
<i>Continued >></i>	

Acute Hemolytic Transfusion Reaction

Component Details (Use worksheet on page 4 for additional units.)								
*Was a particular unit implicated in (i.e., responsible for) the adverse reaction? <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	*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"/> B+ <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <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"/> B+ <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N
____/____/____ ____:____ ____/____/____ ____:	<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"/> B+ <input type="checkbox"/> O-	<input type="checkbox"/> A+ <input type="checkbox"/> AB- <input type="checkbox"/> O+	<input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> N/A	N

Custom Fields	
Label _____ _____ _____	Label _____ _____ _____
Comments	
_____ _____ _____ _____	

Hemovigilance Module Additional Worksheet

Patient Medical History

(part 1) List the patient's admitting diagnosis. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____

(part 2) List the patient's underlying indication for transfusion. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____

(part 3) 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: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____

(part 4) 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: _____
Code: _____	Description: _____
Code: _____	Description: _____
Code: _____	Description: _____

(part 5) Additional Information _____

Hemovigilance Module Additional Worksheet

Transfusion History
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>
<p>Has the patient received a previous transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>**If yes, provide information about the transfusion event. If not, skip to Reaction Details section.</i></p> <p>Blood Product: <input type="checkbox"/> WB <input type="checkbox"/> RBC <input type="checkbox"/> Platelet <input type="checkbox"/> Plasma <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Granulocyte</p> <p>Date of Transfusion: ___/___/___ <input type="checkbox"/> UNKNOWN</p> <p>Did the patient experience a transfusion adverse reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, provide information about the transfusion adverse reaction.</p> <p>Type of transfusion adverse reaction: <input type="checkbox"/> Allergic <input type="checkbox"/> AHTR <input type="checkbox"/> DHTR <input type="checkbox"/> DSTR <input type="checkbox"/> FNHTR</p> <p><input type="checkbox"/> HTR <input type="checkbox"/> TTI <input type="checkbox"/> PTP <input type="checkbox"/> TACO <input type="checkbox"/> TAD <input type="checkbox"/> TA-GVHD <input type="checkbox"/> TRALI <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> OTHER Specify _____</p>
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Hemovigilance Module Additional Worksheet

Component Details								
*Was a particular unit implicated in (i.e., responsible for) the adverse reaction? <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	*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			N
____/____/____ ____:____ ____/____/____ _____	<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
____/____/____ ____:____ ____/____/____ _____	<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
____/____/____ ____:____ ____/____/____ _____	<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
____/____/____ ____:____ ____/____/____ _____	<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
____/____/____ ____:____ ____/____/____ _____	<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
____/____/____ ____:____ ____/____/____ _____	<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
____/____/____ ____:____ ____/____/____ _____	<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