



Hemovigilance Module Adverse Reaction Transfusion Associated Circulatory Overload

*Required for saving

*Facility ID#: _____ NHSN Adverse Reaction #: _____

Patient Information

*Patient ID: _____ *Gender: M F Other *Date of Birth: ___/___/___

Sex at Birth: M F Unknown

Gender Identity (Specify) _____

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

* **Transfusion associated circulatory overload (TACO)**

***Case Definition**

Check all that occurred within 6 hours of cessation of transfusion (new onset or exacerbation):

- Acute respiratory distress (dyspnea, orthopnea, cough)
- Elevated brain natriuretic peptide (BNP)
- Elevated central venous pressure (CVP)
- Evidence of left heart failure
- Evidence of positive fluid balance
- Radiographic evidence of pulmonary edema

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

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 explanations for circulatory overload are possible.
- Transfusion is a likely contributor to circulatory overload
- The patient has a history of a pre-existing condition(s) that most likely explains circulatory overload.
- 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

Does the patient have a history of cardiac insufficiency?

- Yes, the patient has a history of cardiac insufficiency that could explain the circulatory overload, but transfusion is just as likely to have caused the circulatory overload.
- Yes, the patient has a history of pre-existing cardiac insufficiency that most likely explains circulatory overload.
- No, the patient does not have a history of cardiac insufficiency.

Did the patient received other fluids in addition to the transfusion? 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
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Comments
