

Form Approved OMB No. 0920-0666 Exp. Date: 12/31/22 www.cdc.gov/nhsn

Hemovigilance Module Adverse Reaction Other Transfusion Reaction

*Required for saving	
*Facility ID#: NHSN A	dverse Reaction #:
Patient Information	
*Patient ID:	
Social Security #:	
Last Name:	First Name: Middle Name:
Ethnicity Hispanic or Latino	☐ Not Hispanic or Not Latino
Race	
☐ Native Hawaiian/Oth	er Pacific Islander
*Blood Group: A- A+ D	B- □B+ □ AB- □ AB+ □ O- □ O+ □ Blood type not done
	Rh + Transitional ABO / Rh - Transitional ABO / Transitional Rh
☐ Group A/Transitional Rh ☐ Group	b B/Transitional Rh Group O/Transitional Rh Group AB/Transitional Rh
Patient Medical History	
List the patient's admitting diagno	osis. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
Code:	Description:
Code:	Description:
List the patient's underlying indica	ation for transfusion. (Use ICD-10 Diagnostic codes/descriptions)
Code:	Description:
Code:	Description:
Code:	Description:
List the patient's comorbid condit reaction. (Use ICD-10 Diagnostic	ions at the time of the transfusion related to the adverse UNKNOWN Codes/descriptions)
Code:	Description:
Code:	Description:
Code:	Description:
of any individual or institution is collected vistated, and will not otherwise be disclosed Sections 304, 306 and 308(d) of the Public Public reporting burden of this collection of reviewing instructions, searching existing collection of information. An agency may runless it displays a currently valid OMB co	rily provided information obtained in this surveillance system that would permit identification with a guarantee that it will be held in strict confidence, will be used only for the purposes or released without the consent of the individual, or the institution in accordance with the Health Service Act (42 USC 242b, 242k, and 242m(d)). If information is estimated to average 20 minutes per response, including the time for data sources, gathering and maintaining the data needed, and completing and reviewing the not conduct or sponsor, and a person is not required to respond to a collection of information introl number. Send comments regarding this burden estimate or any other aspect of this tions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, 16).



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DE UNKNOWN

•	nedical procedure including past procedu	. — — — — — — — — — — — — — — — — — — —					
codes/descriptions)	nt hospital or outpatient stay. (Use ICD-1	∪ Procedure					
Code:	Description:						
Code:							
	•						
Additional Information							
Transfusion History							
Has the patient received a	previous transfusion?	∕ES □ NO □ UNKNOWN					
•]WB □ RBC □ Platelet □ Plasr	ma Cryoprecipitate Granulocyte					
Date of Transfusion:	/						
Was the patient's advers	e reaction transfusion-related?	☐ YES ☐ NO					
If yes, provide informatio	n about the transfusion adverse reaction.						
Type of transfusion adve	rse reaction:	DHTR DSTR FNHTR					
☐ HTR ☐ TTI	☐ PTP ☐ TACO ☐ TAD ☐ TA	-GVHD TRALI UNKNOWN					
☐ OTHER Speci	fy						
Reaction Details							
*Date reaction occurred:	//_ *Time reaction occurred:	:					
*Facility location where pati	ent was transfused:						
Is this reaction associated with	h an incident?						
Investigation Results							
Investigation Results * Other							
* Other							
* Other							
* Other Specify: List tests relevant to reac							
* Other Specify: List tests relevant to reactive test name:	tion investigation:	Test result:					
* Other Specify: List tests relevant to react Test name: Test name:	tion investigation: Testing date: Testing date:	Test result:					
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms:	tion investigation: Testing date: Testing date:(check all that apply)	Test result: Test result:					
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors	Test result:					
* Other Specify: List tests relevant to reactors the street name: Test name: Other signs and symptoms: Generalized: Cardiovascular:	tion investigation: Testing date: Testing date:(check all that apply)	Test result: Test result: Nausea/vomiting					
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease	Test result: Test result: Nausea/vomiting Shock Jaundice					
* Other Specify: List tests relevant to reactors name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing	Test result: Test result: Nausea/vomiting Shock Jaundice Urticaria (hives)					
* Other Specify: List tests relevant to reactors the street name: Test name: Other signs and symptoms: Generalized: Cardiovascular:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Bdema Pruritus (itching)	Test result: Test result: Nausea/vomiting Shock Jaundice Urticaria (hives)					
* Other Specify: List tests relevant to reactors name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Testing date: Pruritus (itching)	Test result: Test result: Nausea/vomiting Shock Jaundice Urticaria (hives)					
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (itching Disseminated intravascular coagular Positive antibody screen	Test result: Test result: Nausea/vomiting Shock Jaundice Jaundice Urticaria (hives) tion Hemoglobinemia					
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage: Pain: Renal:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (itching) Disseminated intravascular coagula Positive antibody screen Abdominal pain Back pain	Test result: Test result: Nausea/vomiting Shock Jaundice Jaundice Urticaria (hives) tion Hemoglobinemia					
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage: Pain: Renal: Respiratory:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (itching) Disseminated intravascular coagulat Positive antibody screen Abdominal pain Back pain Hematuria Hemoglobinus	Test result: Test result: Nausea/vomiting Shock Jaundice ng) Urticaria (hives) tion Hemoglobinemia Flank pain Infusion site pain ria Oliguria Bronchospasm Cough					
* Other Specify: List tests relevant to react Test name: Test name: Other signs and symptoms: Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage: Pain: Renal:	tion investigation: Testing date: Testing date: (check all that apply) Chills/rigors Blood pressure decrease Edema Flushing Other rash Pruritus (itching) Disseminated intravascular coagular Positive antibody screen Abdominal pain Back pain Hematuria Hemoglobinut	Test result: Test result: Nausea/vomiting Shock Jaundice ng) Urticaria (hives) tion Hemoglobinemia Flank pain Infusion site pain ria Oliguria Bronchospasm Cough					



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*Severity						
Did the patient receive or experience any of the fo	ollowing?					
☐ No treatment required	☐ No treatment required ☐ Symptomatic treatment only					
Hospitalization, inlcuding prolonged hospital	alization	Life-threatening	reaction			
☐ Disability and/or incapacitation	☐ Congenital anom	aly 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? Conclusive evidence exists that the adverse reaction can be attributed to the transfusion. Evidence is clearly in favor of attributing the adverse reaction to the transfusion or an alternate cause.						
 □ Evidence is indeterminate for attributing the adverse reaction to the transfusion or an alternate 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 						
Module-generated Designations						
NOTE: Designations for case definition, severity, and application based on responses in the corresponding in			in the NHSN			
*Do you agree with the <u>case definition</u> designation	ation?	YES	□NO			
*Do you agree with the <u>severity</u> designation? ^Please indicate your designation		☐ YES	□NO			
*Do you agree with the <u>imputability</u> designation ^Please indicate your designation	n?	☐ YES	□ NO			
Patient Treatment						
Did the patient receive treatment for the transfusion If yes, select treatment(s): Medication (Select the type of medication) Antipyretics Antihistamines		YES NO	☐ UNKNOWN or ☐ Diuretics			
☐ Intravenous Immunoglobulin ☐ Intravenous Immunoglobulin ☐ Cyclosp	venous steroids	Corticosteroids	☐ Antibiotics			
☐ Volume resuscitation (Intravenous colloids o	r crystalloids)					
☐ Respiratory support (Select the type of supp☐ Mechanical ventilation☐ Noninva	oort) sive ventilation	Oxygen				
☐ Renal replacement therapy (Select the type ☐ Hemodialysis ☐ Peritoneal ☐ 0	<i>of therapy)</i> Continuous Veno-Ver	nous Hemofiltration				
☐ Phlebotomy ☐ Other Specify:						



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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	Component Details									
*Was a particular unit implicated in (i.e., responsible for) the adverse Pes No N/A										
Transfusion Start and End	*Component code	Amount transfused at	^Unit number (Required for Infection and	*Unit expiration			Implic ated			
Date/Time	(check system used)	reaction onset	TRALI)	Date/Time				Unit?		
^IMPLICATED	UNIT			1				1		
/	☐ ISBT-128									
:	☐ Codabar	☐ Entire unit ☐ Partial unit			□ A-	□ A+	□ B-	Y		
/ /		mL			Пв+	П АВ-	П ав+	ī		
						□ O+	_ □ N/A			
	☐ ISBT-128			·						
	☐ Codabar	☐ Entire unit			□ A-	□ A+	П в-			
	□ Codabar	Partial unit					_	N		
//					□В+	☐ AB-	☐ AB+			
::				l:	□ O-	□ O+	□ N/A			
Custom Fields										
Label			Label							
Comments										



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