

Hemovigilance Module Adverse Reaction Unknown Transfusion Reaction

*Required for saving	J				
*Facility ID#:					
Patient Information	n				
*Patient ID:		*Date of Birth://			
*Sex: ∐M ∐F					
Social Security #:	Secondary ID: Medicare #:				
Last Name:					
Ethnicity (Specify):		nic or Latino Unknown Declined to respond			
Race (Select all that apply):	American Indian or Asian Alaska Native Native Hawaiian or White Pacific Islander	Black or AfricanMiddle Eastern or NorthAmericanAfricanUnknownDeclined to respond			
Preferred Language (S	Specify from the list provided):	Interpreter Needed: Yes No			
*Blood Group: 🗌 A-	□ A+ □ B- □B+ □ AB- [☐ AB+ □ O- □ O+ □ Blood type not done			
🗌 Tran	nsitional ABO / Rh + 🛛 Transitio	onal ABO / Rh -			
Group A/Transitional	I Rh 🗌 Group B/Transitional Rh 🗌	Group O/Transitional Rh Group AB/Transitional Rh			
Patient Medical His	story				
List the patient's ad	mitting diagnosis. (Use ICD-10 Diagr	nostic codes/descriptions)			
Code:	Description:				
Code:	Description:				
Code:	Code: Description:				
List the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions)					
Code:	Description:				
Code:					
Code:					
	morbid conditions at the time of the ti 10 Diagnostic codes/descriptions)	ransfusion related to the adverse			
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 57.319 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).

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codes/descriptions)	medical procedure including past proce ent hospital or outpatient stay. <i>(Use ICI</i>		
Code:	Description:		
Code:	Description:		
Code:	Description:		
Additional Information			
Transfusion History			
Has the patient received a	a previous transfusion?	YES NO L	INKNOWN
Blood Product:	WB RBC Platelet Pl	asma 🗌 Cryoprecipitate	Granulocyte
Date of Transfusion:		l	
Was the patient's adver	se reaction transfusion-related?	🗌 YES 🛛 NO	
If yes, provide information	on about the transfusion adverse reaction	on.	
	erse reaction:		
	cify		
Reaction Details			
*Date reaction occurred:	_// *Time reaction occurre	ed:: Time	eunknown
*Facility location where part	tient was transfused:		
Is this reaction associated wi	th an incident? Yes No	If Yes, Incident #:	
Investigation Desults			
Investigation Results			
[•] Unknown			
[•] Unknown			
Diagnosis of case: List tests relevant to read			
Diagnosis of case: List tests relevant to read	ction investigation:		
Unknown Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom	ction investigation: Testing date: Testing date: s: <u>(check all that apply)</u>	Test result: Test result:	
Unknown Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom	ction investigation: Testing date: Testing date:	Test result: Test result:	
Unknown Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom	ction investigation: Testing date: Testing date: s: <u>(check all that apply)</u>	Test result: Test result:	
Image: Second symptom Diagnosis of case: Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom Generalized: Cardiovascular:	ction investigation: Testing date: Testing date: s: (check all that apply) Chills/rigors	Test result: Test result: Nausea/vomiting	
 Unknown Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom Generalized: 	ction investigation: Testing date: Testing date: (check all that apply) Chills/rigors Fever Blood pressure decrease	Test result:	
Image: Second symplemetry Diagnosis of case: Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom Generalized: Cardiovascular: Cutaneous:	ction investigation: Testing date: Testing date: : (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (ite	Test result: Test result: Test result: Nausea/vomiting Shock Jaundice ching) Urticaria (hiv	/es)
Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom Generalized: Cardiovascular:	ction investigation: Testing date: Testing date: : (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (ite	Test result: Test result: Test result: Nausea/vomiting Shock Jaundice ching) Urticaria (hiv	/es)
Image: Second symplemetry Diagnosis of case: Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom Generalized: Cardiovascular: Cutaneous:	ction investigation: Testing date: Testing date: S: (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (ite Disseminated intravascular coag	Test result: Test result: Test result: Nausea/vomiting Shock Jaundice ching) Urticaria (hiv	/es)
Image: Second structure Diagnosis of case: Diagnosis of case: List tests relevant to read Test name: Test name: Other signs and symptom Generalized: Cardiovascular: Cutaneous: Hemolysis/Hemorrhage:	ction investigation: Testing date: Testing date: (check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (itr Disseminated intravascular coag Positive antibody screen	Test result: Test result: Nausea/vomiting Shock Jaundice ching) Urticaria (hiv ulation Hemoglobine Flank pain	res) emia
Image: Constraint of the sector of the se	ction investigation: Testing date: Testing date: Check all that apply) Chills/rigors Fever Blood pressure decrease Edema Flushing Other rash Pruritus (ite Disseminated intravascular coag Positive antibody screen Abdominal pain Back pain	Test result:	res) emia
Image: Constraint of the sector of the se	ction investigation: Testing date: Testing date: <u>Testing date:</u> S: (check all that apply) Chills/rigors Fever Blood pressure decrease Blood pressure decrease Edema Flushing Other rash Pruritus (itu Disseminated intravascular coag Positive antibody screen Abdominal pain Back pain Hematuria Hemoglobi	Test result: Test result: Nausea/vomiting Shock Jaundice ching) Urticaria (hiv ulation Hemoglobine Flank pain [inuria Oliguria Bronchospasm [res) emia] Infusion site pain
Image: Constraint of the sector of the se	ction investigation: Testing date: Testing date: Testing date: Check all that apply) Chills/rigors Fever Blood pressure decrease Blood pressure decrease Edema Flushing Other rash Pruritus (ite Disseminated intravascular coag Positive antibody screen Abdominal pain Back pain Hematuria Hemoglobi Bilateral infiltrates on chest x-ray	Test result: Test result: Nausea/vomiting Shock Jaundice ching) Urticaria (hiv ulation Hemoglobine Flank pain [inuria Oliguria Bronchospasm [res) emia] Infusion site pain

Did the patient receive or experience any of the following?

NHSN NATIONAL HEALTHCARE SAFETY NETWORK	Form Approved OMB No. 0920-0666 Exp. Date: 12/31/2027 www.cdc.gov/nhsn	6 7		
No treatment required Symptomatic	ic treatment only			
Hospitalization, inlcuding prolonged hospitalization	Life-threatening reaction			
Disability and/or incapacitation	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? 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. 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 The relationship between the adverse reaction and the trans				
Did the transfusion occur at your facility?				
Module-generated Designations				
NOTE: Designations for case definition, severity, and imputability will application based on responses in the corresponding investigation res				
* Do you agree with the <u>case definition</u> designation? ^Please indicate your designation				
* Do you agree with the <u>severity</u> designation? ^ Please indicate your designation	YES NO			
*Do you agree with the <i>imputability</i> designation? ^Please indicate your designation	YES NO			
Patient Treatment				
Did the patient receive treatment for the transfusion reaction? If yes, select treatment(s): Medication (Select the type of medication) Antipyretics Antipyretics Intravenous Immunoglobulin Intravenous steroids Antithymocyte globulin		cs		
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 Vend 	o-Venous Hemofiltration			
Phlebotomy Other Specify:				
Outcome				

Image: NHSN MATIONAL HEALTHCARE SAFETY NETWORKForm Approved OMB No. 0920-0666 Exp. Date: 12/31/2027 www.cdc.gov/nhsn									
*Outcome: Death Major or long-term sequelae Minor or no sequelae Not determined									
Date of	Death:/_	/							
^lf ı	recipient died, relation	ship of transfus	ion to	death:					
	Definite 🗌 Probable	e 🗌 Possibl	e [Doubtful	Ruled Out	t 🗌] Not de	etermine	ed
Cause	of death:								
Was an	autopsy performed?	🗌 Yes	🗌 No)					
Component	Details								
*Was a partie reaction?	cular unit implicate	d in (i.e., respo			dverse		s 🗌	No [] N/A
Transfusion Start and End Date/Time	*Component code (check system used)	Amount transfused at reaction onset			*Unit expiration Date/Time	*Blood group of unit		Implic ated Unit?	
^IMPLICATED	UNIT			·	-				
1 1	☐ ISBT-128								
· ·	□ Codabar	🗌 Entire unit				□ A-	□ A+	П В-	
·		Partial unit mL			//				Y
//				·		□B+	□ AB-	□ AB+	
;					::	0-	0+	□ N/A	
//	☐ ISBT-128			·					
;	🗌 Codabar	Entire unit Partial unit			//	□ A-	□ A+	🗆 В-	N
//		mL		·		□в+	🗆 АВ-	🗆 AB+	
::				<u></u>	:	0-	0+	□ N/A	
Custom Field	ds								
Label				Label					
		//	-				/	/	
Comments									