Form Approved
OMB No. 0920-0666
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www.cdc.gov/nhsn

# Hemovigilance Module
# Adverse Reaction
# Transfusion Associated Circulatory Overload

***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. *(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 12 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: | ☐ 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 ☐ Positive antibody screen |
| 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, inlcuding 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** | | | | | | | | |
| ____/____/___<br>___ ___:____<br>____/____/___<br>___ ___:____ | ☐ ISBT-128<br>☐ Codabar<br>___ ___ ___ ___ ___<br>_____ | ☐ Entire unit<br>☐ Partial unit<br>_____mL | __ __ __ __ __<br>__ __<br>__ __ __ __ __ __<br>__ __ __ | ___/___/_____<br>_____:_____ | ☐ A-<br>☐ B+<br>☐ O- | ☐ A+<br>☐ AB-<br>☐ O+ | ☐ B-<br>☐ AB+<br>☐ N/A | Y |
| ____/____/___<br>___ ___:___ _<br>____/____/___<br>___ ___:____ | ☐ ISBT-128<br>☐ Codabar<br>___ ___ ___ ___ ___<br>_____ | ☐ Entire unit<br>☐ Partial unit<br>_____mL | __ __ __ __ __<br>__ __<br>__ __ __ __ __ __<br>__ __ __ | ___/___/_____<br>_____:_____ | ☐ A-<br>☐ B+<br>☐ O- | ☐ A+<br>☐ AB-<br>☐ O+ | ☐ B-<br>☐ AB+<br>☐ N/A | N |

## Custom Fields

| Label | | Label | |
|---|---|---|---|
| _____ | _____/_____/_____ | _____ | _____/_____/_____ |
| _____ | _____ | _____ | _____ |

## Comments