

Hemovigilance Module Adverse Reaction Transfusion Related Acute Lung Injury

*Required for saving NHSN Adverse Reaction #: ____ *Facility ID#: _____ Patient Information *Patient ID: _____ *Gender: M F Other *Date of Birth: ___/__/ Social Security #: _____ Secondary ID: _____ Medicare #: _____ First Name: Middle Name: Last Name: Ethnicity Hispanic or Latino ☐ Not Hispanic or Not Latino American Indian/Alaska Native Asian Black or African American Race Native Hawaiian/Other Pacific Islander ☐ White ***Blood Group:** □ A- □ A+ □ B- □B+ □ AB-□ AB+ □ 0-□0+ ☐ 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: Description: Code: _____ Code: Description: List the patient's underlying indication for transfusion. (Use ICD-10 Diagnostic codes/descriptions) Code: _____ 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) ☐ NONE Code: Description: Description: Code: _____ 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)). 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 D-74,

Atlanta, GA 30333 ATTN: PRA (0920-0666).



	the patient's relevant medical procedure including past procedures and procedures to be ormed during the current hospital or outpatient stay. (Use ICD-10 Procedure les/descriptions)					
	Code: Description:					
	Code: Description:					
	Code: Description:					
	Additional Information					
Transfusion History						
	Has the patient received a previous transfusion?					
	Blood Product:					
	Date of Transfusion:/ UNKNOWN					
	Was the patient's adverse reaction transfusion-related?					
	If yes, provide information about the					_
	Type of transfusion adverse reaction:					
	☐ HTR ☐ TTI ☐ PTP					UNKNOWN
_						
	action Details		.•			
	*Date reaction occurred:// *Time reaction occurred:: Time unknown					
	cility location where patient was tr					
Is this reaction associated with an incident? Yes No If Yes, Incident #:						
	41 41 B 14					
	restigation Results		2.4.1.			
	restigation Results Transfusion related acute lung ir	ijury (TF	RALI)	ı		
		njury (TF	RALI)		Test result positive	Not tested for
		njury (TF	RALI)	Cognate or cross reacting	Test result positive No cognate or cross reacting	Not tested for cognate
	Transfusion related acute lung ir		RALI) Negative	Cognate or	No cognate or	
	Transfusion related acute lung in	Not Done	,	Cognate or cross reacting	No cognate or cross reacting	cognate
	Transfusion related acute lung ir	Not Done	,	Cognate or cross reacting	No cognate or cross reacting antigen present	cognate
	Transfusion related acute lung in	Not Done	,	Cognate or cross reacting	No cognate or cross reacting	cognate
	Donor or unit HLA specificity Donor or unit HNA specificity	Not Done	Negative	Cognate or cross reacting	No cognate or cross reacting antigen present	cognate antigen
	Donor or unit HLA specificity Donor or unit HNA specificity Recipient HLA specificity Recipient HNA specificity *Case Definition (Check all that applied)	Not Done	Negative	Cognate or cross reacting antigen present	No cognate or cross reacting antigen present	cognate antigen
	Donor or unit HLA specificity Donor or unit HNA specificity Recipient HLA specificity Recipient HNA specificity *Case Definition (Check all that application) NO evidence of acute lung injuries	Not Done	Negative □ □ □ □ □ orior to trans	Cognate or cross reacting antigen present	No cognate or cross reacting antigen present	cognate antigen
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	☐ Edema ☐ Flushi	ing 🗌 Jaundice 🛭	☐ Itching ☐ Hive	es	
Hemolysis/Hemorrhage:	Hemolysis/Hemorrhage:				
Pain:	Abdominal pain	Back pain] Flank pain ☐ In	fusion site pain	
Renal:	☐ Hematuria	☐ Hemoglobinuria] Oliguria	
Respiratory:	☐ Bronchospasm ☐	Cough Shortness	s of breath O	ther: (specify)	
*Severity			,		
Did the patient receive or experience any of the following?					
☐ No treatment required ☐ Symptomatic treatment only					
☐ Hospitalization, inl	☐ Hospitalization, inlcuding prolonged hospitalization ☐ Life-threatening reaction				
☐ Disability and/or in	ncapacitation	☐ Congenital anom	naly or birth defect(s	s) of the fetus	
Other medically in	nportant conditions	☐ Death	Unknown or no	ot stated	
*Imputability					
Which best describes the	relationship between the	he transfusion and the	reaction?		
☐ There are no alterna	ative risk factors for ALI	I present.			
☐ There is evidence o	of other causes for acute	e lung injury.			
	Evidence is clearly in favor of a cause other than the transfusion, but transfusion cannot be excluded.				
<u> </u>	☐ There is conclusive evidence beyond reasonable doubt of a cause other than the transfusion				
☐ The relationship bet	☐ 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 Design					
NOTE: Designations for case application based on respons				ed in the NHSN	
*Do you agree with the		nation?	☐ YES	□NO	
^Please indicate your de	eignation				
	Signation				
*Do you agree with the	severity designation?	?	☐ YES	□NO	
^Please indicate your de	severity designation?		<u>—</u>		
*Please indicate your de	severity designation? signation imputability designat		☐ YES	□ NO	
^Please indicate your de	severity designation? signation imputability designat		<u>—</u>		
*Do you agree with the *Please indicate your de Patient Treatment	severity designation? signation imputability designatesignation	ion?	<u>—</u>		
*Do you agree with the *Please indicate your de	severity designation? esignation imputability designatesignation esignation	ion?	YES		
*Do you agree with the *Please indicate your de *Please indicate your de Patient Treatment Did the patient receive trea If yes, select treatment(s)	severity designation? esignation imputability designatesignation esignation	ion?	YES		
*Do you agree with the *Please indicate your de *Please indicate your de Patient Treatment Did the patient receive trea If yes, select treatment(s)	severity designation? esignation imputability designatesignation atment for the transfusion:	ion? on reaction?	YES NO	□ NO □ UNKNOWN	
*Please indicate your de *Do you agree with the *Please indicate your de Patient Treatment Did the patient receive trea If yes, select treatment(s) Medication (Select	severity designation? esignation imputability designate esignation atment for the transfusion the type of medication) Antihistamines	ion? on reaction?	YES NO	□ NO □ UNKNOWN	
*Please indicate your de *Do you agree with the *Please indicate your de Patient Treatment Did the patient receive trea If yes, select treatment(s) Medication (Select	severity designation? esignation imputability designatesignation atment for the transfusion: the type of medication) Antihistamines mmunoglobulin Intremedication	ion? on reaction?	YES NO Sors Bronchodi Corticosteroids	□ NO □ UNKNOWN	
*Please indicate your de *Do you agree with the *Please indicate your de Patient Treatment Did the patient receive trea If yes, select treatment(s) Medication (Select Antipyretics Intravenous In Antithymocyte	severity designation? esignation imputability designatesignation atment for the transfusion: the type of medication) Antihistamines mmunoglobulin Interpretation	ion? on reaction? Inotropes/Vasopress ravenous steroids porin	YES NO Sors Bronchodi Corticosteroids	□ NO □ UNKNOWN	
*Please indicate your de *Do you agree with the *Please indicate your de Patient Treatment Did the patient receive trea If yes, select treatment(s) Medication (Select Antipyretics Intravenous Ir Antithymocyte	severity designation? esignation imputability designatesignation atment for the transfusion: the type of medication) Antihistamines mmunoglobulin	ion? on reaction? Inotropes/Vasopress ravenous steroids sporin Other	YES NO Sors Bronchodi Corticosteroids	□ NO □ UNKNOWN	



Ren	al replacement therap	y (Select the ty	pe of t	herapy)				3
] Hemodialysis 🔲 F	Peritoneal [☐ Cor	ntinuous Ven	o-Venous Hen	nofiltratio	n	
	ebotomy							
Othe	er Specify:							
Outcome	_							
	*Outcome: Death Major or long-term sequelae Minor or no sequelae Not determined						mined	
Date of		/	: 4-	al a a 41b .				
	^If recipient died, relationship of transfusion to death: ☐ Definite ☐ Probable ☐ Possible ☐ Doubtful ☐ Ruled Out ☐ Not determined						od	
	of death:	5 [] F055ibi	ן פ		∐ Ruled O	JL] Not determin	eu
	autopsy performed?	□Yes	□ No)				
*Was a partic	cular unit implicated	d in (i.e., respo	nsibl	e for) the a	dverse			
reaction?						Yes	s No [N/A
Transfusion	Amount Amount Amount *Unit number (Required for *Unit			*Unit	Imp			
Start and End Date/Time	*Component code (check system used)	transfused at reaction onset		ction and expiration		*Blood group of unit		ated Unit?
^IMPLICATED	<u> </u>	reaction onset	INAL	.1)	Date/Tille	or un	<u> </u>	Office
	☐ ISBT-128							
//		☐ Entire unit				□ A-	□ A+ □ B-	
:	☐ Codabar	Partial unit	<u> </u>			A-		Υ
/		mL		. — — — —		□В+	☐ AB- ☐ AB+	
:				. <u></u>	::	□ 0-	□ O+ □ N/A	
/	☐ ISBT-128							
:	☐ Codabar	☐ Entire unit ☐ Partial unit			//	□ A-	□ A+ □ B-	N
/		mL				□в+	□ AB- □ AB+	
:					:	□ 0-	□ O+ □ N/A	
Custom Field	ds							
Label				Label				
		′/	-				//	
Comments								



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