OMB No. 0920-0666
Exp. Date: xx-xx-20xx

Hemovigilance Module

Annual Facility Survey

*Required fields

*Tracking # / Facility ID: _____ *Survey Year: _____

Facility Characteristics: (For all questions use past full calendar year annual statistics)

*1. Ownership: (Check one)

☐ For profit ☐ Government ☐ Military ☐ Not for profit, including church
☐ Veteran's Affairs ☐ Physician-owned ☐ Managed Care Organization

*2. Is your hospital affiliated with a medical school? ☐ Yes ☐ No
If yes, type of affiliation: ☐ Major ☐ Graduate ☐ Limited

*3. Community setting of facility: ☐ Urban ☐ Suburban ☐ Rural

*4. Total beds set up and staffed: _____

*5. Number of surgeries performed per year: Inpatient _____ Outpatient _____

*6. At what trauma level is your facility certified? _____ ☐ N/A

Transfusion Services Characteristics:

*7. Primary classification of facility areas served by Transfusion Services: (Check all that apply)

☐ General medical and surgical ☐ Obstetrics and gynecology ☐ Orthopedic
☐ Cancer center ☐ Chronic disease ☐ Children's general medical and surgical
☐ Children's orthopedic ☐ Children's cancer center
☐ Children's chronic disease ☐ Other (specify)_____

*8. Is your Transfusion Services part of the facility's core laboratory? ☐ Yes ☐ No

*9. How many dedicated Transfusion Services staff are there?

Number of technical FTEs (including supervisors): _____
Number of dedicated physician FTEs: _____
Number of MLT: _____ Number of MT: _____

Assurance of Confidentiality: The 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 2 hours 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).

*10. Is your Transfusion Services Laboratory Accredited? ☐ Yes ☐ No

If Yes, select all that apply: ☐ College of American Pathologists (CAP) ☐ AABB

*11. How is your hospital accredited? (Check one)

☐ The Joint Commission ☐ Centers for Medicare and Medicaid Services

*12. Do you have a committee that reviews blood utilization? ☐ Yes ☐ No

*13. What is the total number of samples collected in the past year: _____

*14. Products and Units Transfused: (Check all that apply)

☐ Red Blood Cells (RBCs)

Total number of units transfused in the past year: _____

Number of units from which aliquots were made: _____

Number of aliquots transfused: _____

☐ Platelets

Number of units of whole blood derived platelet concentrates transfused: _____

What is your average pool size? _____

Number of units of apheresis platelets transfused: _____

☐ Plasma Number of units transfused: _____ (Incl. FFP, thawed, etc.)

☐ Cryoprecipitate Number of units transfused: _____

☐ Granulocytes Number of units transfused: _____

☐ Lymphocytes Number of units transfused: _____

*15. Are any of the following administered through Transfusion Services? (Check all that apply)

☐ Albumin ☐ Factors (VIIa, VIII, IX, ATIII, etc) ☐ Immunoglobulin (IV)

☐ Immunoglobulin (IM or subcutaneous) ☐ RHIg ☐ None

*16. Does your facility attempt to transfuse only leukocyte-reduced cellular components?

☐ Yes ☐ No

17. Units Transfused by Department/Service

Department/Service	Samples Collected	Units Transfused						
		Platelets		RBCs	Plasma	Cryo	Grans	Lymphs
		Apheresis	Whole Blood Derived					
Emergency Room/Trauma								
Hematology/Oncology (Incl. Bone marrow transplant & apheresis)								
ICU								
Nephrology/Dialysis								
Obstetrics/Gynecology								
Pediatrics/Neonatology								
Surgery – cardiac								
Surgery – general								
Surgery – orthopedic								
Surgery – other								
Transplant – solid organ								

*18. Are all units stored in the Transfusion Services area? ☐ Yes ☐ No

If No, indicate the location of satellite storage: (Check all that apply)

☐ Operating room ☐ Emergency room ☐ Ambulatory care

☐ Other: _____

*19. To what extent does Transfusion Services modify products? (Check all that apply)

☐ Aliquot ☐ Deglycerolizing ☐ Irradiation ☐ Leukoreduction

☐ Plasma reduction ☐ Pooling ☐ Washing ☐ None of these

*20. Do you collect blood for transfusion at your facility? ☐ Yes ☐ No

If Yes, check all that apply: ☐ Allogeneic ☐ Autologous ☐ Directed

*21. Does your facility perform viral testing on blood for transfusion? ☐ Yes ☐ No

Transfusion Services Computerization:

*22. Is Transfusion Services computerized?

☐ Yes ☐ No SKIP to next section

If Yes, system used: (Check all that apply) ☐ Cerner Classic® ☐ Cerner Millenium® ☐ HCLL®

☐ Horizon BB® ☐ Hemocare® ☐ Lifeline® ☐ Meditech® ☐ Mysis®

☐ Wingate® (Safetrace TX) ☐ Softbank® ☐ Western Star®

☐ Other (specify) _____

*23. Is your system ISBT-128 compliant? ☐ Yes ☐ No

*24. Does the Transfusion Services system interface with the patient registration system?

☐ Yes ☐ No

*25. Are Transfusion Services adverse events entered into a hospital-wide reporting computer system?

☐ Yes Specify system used: _____ ☐ No

*26. Do you use positive patient ID technology for transfusion services?

☐ Yes, hospital wide ☐ Yes, certain areas ☐ Not used [SKIP to Q. 27]

If Yes, used for: (Check all that apply) ☐ Specimen collection ☐ Product administration

Indicate system used: (Check all that apply)

☐ Mechanical barrier system (e.g., Bloodloc®)

☐ Separate transfusion ID wristband system (e.g., Typenex®)

☐ Radio frequency identification (RFID)

☐ Bedside ID band barcode scanning

☐ Other (specify) _____

*27. Do you have physician on-line order entry for test requesting? ☐ Yes ☐ No

*28. Do you have physician on-line order entry for product requesting? ☐ Yes ☐ No

Transfusion Service Specimens: Handling/Testing

*29. Are the Transfusion Service specimens drawn by a dedicated phlebotomy team?

☐ Always ☐ Sometimes, approximately ____% of the time ☐ Never

*30. What specimen labels are used at your facility? (Check all that apply)

☐ Handwritten ☐ Addressograph ☐ Computer generated from laboratory test request

☐ Computer generated by bedside device ☐ Other (specify) _____

*31. Are phlebotomy staff allowed to correct errors in patient identification on pre-transfusion specimen labels? ☐ Yes ☐ No

*32. What items can be used to verify patient identification during specimen collection and prior to product administration at your facility? (Check all that apply)

☐ Medical record (or other unique patient ID) number ☐ Date of birth ☐ Gender

☐ Patient first name ☐ Patient last name ☐ Transfusion specimen ID system (e.g., Typenex®)

☐ Patient verbal confirmation of name or date-of-birth ☐ Other (specify) _____

*33. How are routine type and screen done? (Check all that apply)

☐ Manual technique % done_____ ☐ Automatic technique % done_____

☐ Automatic and manual % done_____

*34. Is the ABO group of a pre-transfusion specimen routinely confirmed?

☐ Yes (Check one) ☐ No

☐ All samples

☐ If there is no laboratory record of previous determination of patient's ABO group

☐ If there is no laboratory record of previous determination of patient's ABO group AND the patient is a candidate for electronic crossmatching

If Yes, is the confirmation required on a separately collected specimen before a RBC unit of Group A, B or AB is issued for transfusion? ☐ Yes ☐ No

*35. How many RBC type and crossmatch procedures were performed at your facility by any method?

RBC type: _____

Estimated % done by each method: (Check all that apply)

☐ electronically _____ ☐ serologically _____ ☐ Don't know

RBC crossmatch: _____

Estimated % done by each method: (Check all that apply)

☐ electronically _____ ☐ serologically _____ ☐ Don't know