OMB No. , 0920-0666
EXP. DATE: XX-XX-XXXX

# Hemovigilance Module

## Blood Product Incidents Reporting – Summary data

**Facility ID#: _____ Month __ __/ Year __ __ __ __**

*All reporting is facility-wide. Include numbers of individual reports in the totals.*

| *Process Point | | *Total Number of Incidents | *# of Adverse Transfusion Reactions Associated w/ Incident |
|---|---|---|---|
| **PC - Product Check-In** (Products received from outside source) | PC 00 Detail not specified | | |
| | PC 01 Data entry incomplete/not performed/incorrect | | |
| | PC 02 Shipment incomplete/incorrect | | |
| | PC 03 Product & paperwork do not match | | |
| | PC 04 Shipped under inappropriate conditions | | |
| | PC 05 Inappropriate return to inventory | | |
| | PC 06 Product confirmation | | |
| | PC 07 Administrative check (2nd check) | | |
| **PR - Product/Test Request** (Clinical Service) | PR 00 Detail not specified | | |
| | PR 01 Order for wrong patient | | |
| | PR 02 Order incorrectly entered on-line | | |
| | +PR 03 Special needs not indicated on order (e.g., CMV negative, auto) | | |
| | PR 04 Order not done/incomplete/incorrect | | |
| | PR 05 Inappropriate/incorrect test ordered | | |
| | PR 06 Inappropriate/incorrect blood product ordered | | |
| **SC – Sample Collection** (Service collecting the samples) | SC 00 Detail not specified | | |
| | +SC 01 Sample labeled with incorrect patient name | | |
| | +SC 02 Not labeled | | |
| | +SC 03 Wrong patient collected | | |
| | SC 04 Collected in wrong tube type | | |
| | SC 05 Sample QNS | | |
| | SC 06 Sample hemolyzed | | |
| | +SC 07 Label incomplete/illegible/incorrect (other than patient name) | | |
| | SC 08 Sample collected in error | | |
| | SC 09 Requisition arrives without samples | | |
| | +SC 10 Wristband incorrect/not available | | |
| | SC 11 Sample contaminated | | |

**(Continued)**

**+Indicates high priority codes (individual incident report must be completed)**

**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).

CDC 57.302

| *Process Point | | *Total Number of Incidents | *# of Adverse Transfusion Reactions Associated w/ Incident |
|---|---|---|---|
| **SH – Sample Handling** (Service collecting the samples) | SH 00 Detail not specified | | |
| | SH 01 Sample arrives without requisition | | |
| | SH 02 Requisition & sample label don't match | | |
| | +SH 03 Patient ID incorrect/illegible on requisition | | |
| | SH 05 No phlebotomist/witness identification | | |
| | SH 06 Sample arrives with incorrect requisition | | |
| | SH 07 Patient information (other than ID) missing/incorrect on requisition | | |
| | SH 10 Sample transport issues | | |
| **SR – Sample Receipt** (Transfusion Service) | SR 00 Detail not specified | | |
| | SR 01 Sample processed in error | | |
| | SR 02 Historical review incorrect/not done | | |
| | SR 03 Demographic review/data entry incorrect/ not done | | |
| | SR 04 Sample incorrectly accessioned (test/product) | | |
| | SR 05 Duplicate sample sent | | |
| **ST – Sample Testing** (Transfusion Service) | ST 00 Detail not specified | | |
| | ST 01 Data entry incorrect/not performed | | |
| | ST 02 Appropriate sample checks not done | | |
| | +ST 03 Computer warning overridden | | |
| | ST 05 Sample tube w/ incorrect accession label | | |
| | +ST 07 Sample tubes mixed up | | |
| | +ST 09 Test tubes mislabeled (wrong patient name/number) | | |
| | ST 10 Equipment problem | | |
| | ST 12 Patient testing not performed | | |
| | ST 13 Incorrect testing method chosen | | |
| | ST 14 Testing performed incorrectly | | |
| | ST 15 Test result misinterpreted | | |
| | ST 16 Inappropriate/expired reagents used | | |
| | ST 17 ABO/Rh error caught on final check | | |
| | ST 18 Current & historical ABO/Rh don't match | | |
| | ST 19 Additional testing not performed | | |
| | ST 20 Administrative check at time work performed | | |
| | ST 22 Sample storage incorrect/inappropriate | | |
| **US – Product Storage** (Transfusion Service) | US 00 Detail not specified | | |
| | US 01 Incorrect storage of unit in transfusion service | | |
| | US 02 Expired product in stock | | |
| | US 03 Inappropriate monitoring of storage device | | |
| | US 04 Unit stored on incorrect ABO shelf | | |
| **AV - Available for Issue** (Transfusion Service) | AV 00 Detail not specified | | |
| | AV 01 Inventory audits | | |
| | AV 02 Product status not/incorrectly updated in computer | | |
| | AV 03 Supplier recall | | |
| | AV 04 Product ordered incorrectly/not submitted | | |
| **SE - Product Selection** (Transfusion Service) | SE 00 Detail not specified | | |
| | SE 01 Incorrect product/component selected | | |
| | SE 02 Data entry incomplete/incorrect | | |
| | SE 03 Not checking/incorrect checking of product | | |

| *Process Point | | *Total Number of Incidents | *# of Adverse Transfusion Reactions Associated w/ Incident |
|---|---|---|---|
| | and/or patient information | | |
| | SE 05 Historical file misinterpreted/not checked | | |
| | SE 07 Special processing needs not checked | | |
| | SE 09 Special processing needs not understood or misinterpreted | | |
| | SE 11 Special processing not done | | |
| **UM – Product Manipulation** (Transfusion Service) | UM 00 Detail not specified | | |
| | UM 01 Data entry incomplete/incorrect | | |
| | UM 02 Record review incomplete/incorrect | | |
| | UM 03 Wrong component selected | | |
| | UM 04 Administrative check (at time of manipulation) | | |
| | UM 05 Labeling incorrect | | |
| | +UM 07 Special processing needs not checked | | |
| | +UM 08 Special processing misunderstood or misinterpreted | | |
| | +UM 09 Special processing not done/incorrectly done | | |
| **RP - Request for Pick-up** (Clinical Service) | RP 00 Detail not specified | | |
| | RP 01 Request for pick-up on wrong patient | | |
| | RP 02 Incorrect product requested for pick-up | | |
| | RP 03 Product requested prior to obtaining consent | | |
| | RP 04 Product requested for pick-up pt not available | | |
| | RP 05 Product requested for pick-up IV not ready | | |
| | RP 06 Request for pick-up incomplete | | |
| | RP 10 Product transport issues | | |
| **UI – Product Issue** (Transfusion Service) | UI 00 Detail not specified | | |
| | UI 01 Data entry incomplete/incorrect | | |
| | UI 02 Record review incomplete/incorrect | | |
| | UI 03 Pick-up slip did not match patient information | | |
| | UI 04 Incorrect unit selected (wrong person or right person wrong order) | | |
| | UI 05 Issue delayed | | |
| | +UI 06 LIS warning overridden | | |
| | UI 07 Computer issue not completed | | |
| | UI 09 Not checking/incorrect checking of unit and/or patient information | | |
| | UI 11 Unit delivered to incorrect location | | |
| | UI 19 Wrong product issued | | |
| | UI 20 Administrative review (self, 2nd check at issue) | | |
| | UI 22 Issue approval not obtained/documented | | |
| **UT – Product Administra-tion** (Clinical Service) | UT 00 Detail not specified | | |
| | +UT 01 Administered product to wrong patient | | |
| | +UT 02 Administered wrong product to patient | | |
| | UT 03 Product not administered | | |
| | UT 04 Incorrect storage of product on floor | | |
| | UT 05 Administrative review (unit/patient at bedside) | | |
| | UT 06 Administered product w/ incompatible IV fluid | | |
| | UT 07 Administration delayed | | |
| | UT 08 Wrong unit chosen from satellite refrigerator | | |
| | UT 10 Administered components in inappropriate order | | |

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|---|---|---|---|
| | UT 11 Appropriate monitoring of patient not done | | |
| | UT 12 Floor/clinic did not check for existing products in their area | | |
| | UT 13 Labeling problem on unit | | |
| | UT 19 Transfusion protocol not followed | | |
| Other | MS 99 | | |
| **TOTAL Monthly Reports** | | | |