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: _____

*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