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)

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		

*Process Point		*Total Number of Incidents	*# of Adverse Transfusion Reactions Associated w/ Incident
	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			