OMB No. 0920-0666 Exp. Date: XX-XX-XXXX



## Hemovigilance Module Monthly Incident Summary

*Required for saving						
*Facility ID#:	*Month:	*Year:				
All reporting is facility-wide. Include numbers of individual incident reports in the totals.						
*Process	*Incident Code	*Total Incidents	*Total Adverse Reactions associated with Incidents			
	PC 00 Detail not specified					
PC: Product Check-In	PC 01 Data entry incomplete/not performed/incorrect PC 02 Shipment incomplete/incorrect  PC 03 Product and paperwork do not match					
(Products received	PC 03 Product and paperwork do not match PC 04 Shipped under inappropriate conditions					
from outside	PC 04 Shipped dider mappropriate conditions  PC 05 Inappropriate return to inventory					
source)	PC 06 Product confirmation					
	PC 07 Administrative check (2 <sup>nd</sup> check)					
	PR 00 Detail not specified					
	PR 01 Order for wrong patient					
PR: Product/Test	PR 02 Order incorrectly entered online					
Request	+ PR 03 Special needs not indicated on order (e.g., CMV negative, auto)					
(Clinical Service)	PR 04 Order not done/incomplete/incorrect					
	PR 05 Inappropriate/incorrect test ordered					
	PR 06 Inappropriate/incorrect blood product ordered					
	SC 00 Detail not specified					
	+ SC 01 Sample labeled with incorrect patient name					
	+ SC 02 Not labeled					
	+ SC 03 Wrong patient collected					
SC: Sample	SC 04 Collected in wrong tube type					
Collection	SC 05 Sample QNS					
(Service collecting	SC 06 Sample hemolyzed					
the samples)	+ SC 07 Label incomplete/illegible/incorrect (other than patient name)					
	SC 08 Sample collected in error					
	SC 09 Requisition arrived without samples					
	+ SC 10 Wristband incorrect/not available SC 11 Sample contaminated					
	SH 00 Detail not specified					
	SH 01 Sample arrived without requisition					
SU: Sample	SH 02 Requisition and sample label don't match					
SH: Sample Handling (Service collecting the samples)	+ SH 03 Patient ID incorrect/illegible on requisition					
	SH 05 No phlebotomist/witness identification					
	SH 06 Sample arrived with incorrect requisition					
	SH 07 Patient information (other than ID) missing/incorrect on requisition					
	SH 10 Sample transport issue					

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 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 CDC 57.302 Rev. 1, v6.4

<sup>+</sup> Indicates high-priority incidents; individual incident report must be completed for each.

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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).

*Process	*Incident Code	*Total	*Total Adverse Reactions associated with
Coue		Incidents	Incidents
	SR 00 Detail not specified		
SR: Sample	SR 01 Sample processed in error		
Receipt	SR 02 Historical review incorrect/not done		
(Transfusion	SR 03 Demographic review/data entry incorrect/not done		
Service)	SR 04 Sample incorrectly accessioned (test/product)		
	SR 05 Duplicate sample sent		
	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: Sample	ST 10 Equipment problem		
Testing	ST 12 Patient testing not performed		
(Transfusion	ST 13 Incorrect testing method chosen		
Service)	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 and 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. Droduot	US 00 Detail not specified		
US: Product	US 01 Incorrect storage of unit in transfusion service		
Storage (Transfusion	US 02 Expired product in stock		
Service)	US 03 Inappropriate monitoring of storage device		
Service)	US 04 Unit stored on incorrect ABO shelf		
AV/- A! -! !	AV 00 Detail not specified		
AV: Available for	AV 01 Inventory audit		
Issue	AV 02 Product status not/incorrectly updated in computer		
(Transfusion	AV 03 Supplier recall		
Service)	AV 04 Product ordered incorrectly/not submitted		
	SE 00 Detail not specified		
	SE 01 Incorrect product/component selected		
SE: Product	SE 02 Data entry incomplete/incorrect		
Selection	SE 03 Not/incorrect checking of product and/or patient information		
(Transfusion	SE 05 Historical file misinterpreted/not checked		
Service)	SE 07 Special processing needs not checked		
, , , , , , , , , , , , , , , , , , ,	SE 09 Special processing needs not understood or misinterpreted		
	SE 11 Special processing not done		
UM: Product	UM 00 Detail not specified		
Manipulation	UM 01 Data entry incomplete/incorrect		
(Transfusion	UM 02 Record review incomplete/incorrect		
Service)	UM 03 Wrong component selected		
,	UM 04 Administrative check (at time of manipulation)		
	UM 05 Labeling incorrect		
	+ UM 07 Special processing needs not checked		
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	+ UM 08 Special processing needs misunderstood or misinterpreted	
	+ UM 09 Special processing not done/incorrectly done	

+ Indicates high-priority incidents; individual incident report must be completed for each.

*Process	*Incident Code	*Total Incidents	*Total Adverse Reactions associated with Incidents
	RP 00 Detail not specified		
DD. Dogwood for	RP 01 Request for pick-up on wrong patient		
	RP 02 Incorrect product requested for pick-up		
RP: Request for Pick-up	RP 03 Product requested prior to obtaining consent		
(Clinical Service)	RP 04 Product requested for pick-up, patient not available		
(Cililical Service)	RP 05 Product requested for pick-up, IV not ready		
	RP 06 Request for pick-up incomplete		
	RP 10 Product transport issue		
	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: Product Issue	UI 05 Product issue delayed		
(Transfusion	+ UI 06 LIS warning overridden		
Service)	UI 07 Computer issue not completed		
	UI 09 Not/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, 2 <sup>nd</sup> check at issue)		
	UI 22 Issue approval not obtained/documented		
	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: Product	UT 05 Administrative review (unit/patient at bedside) UT 06 Administered product w/incompatible IV fluid		
Administration	UT 07 Administration delayed		
(Clinical Service)	UT 08 Wrong unit chosen from satellite refrigerator		
	UT 10 Administered components in inappropriate order 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		
MS: Other	MS 99 Other		
IVIS. ULITEI			
	Total		

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