



Hemovigilance Module Incident

*Required for saving

*Facility ID#:	NHSN Incident #:	Local Incident # or Log #:
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Discovery

*Date of discovery: ___ / ___ / _____

*Time of discovery: ___ : ___ (HH:MM) Time approximate Time unknown

*Where in the facility was the incident discovered? _____

*How was the incident **first discovered**? (check one)

- | | |
|---|--|
| <input type="checkbox"/> Communication from lab to floor | <input type="checkbox"/> Observation by staff of unit/plate/reagent/sample/equipment |
| <input type="checkbox"/> Comparison of product label to patient information | <input type="checkbox"/> Patient transfusion reaction |
| <input type="checkbox"/> Comparison of product label to physician order | <input type="checkbox"/> Repeat or sample re-testing |
| <input type="checkbox"/> Comparison of sample to paperwork | <input type="checkbox"/> Routine audit or supervisory review |
| <input type="checkbox"/> Computer system alarm or warning | <input type="checkbox"/> Visual inventory review |
| <input type="checkbox"/> Historical record/previous type check | <input type="checkbox"/> When checking patient ID band |
| <input type="checkbox"/> Human 'lucky catch' | <input type="checkbox"/> When product/units returned to lab |
| <input type="checkbox"/> Notification or complaint from floor (nurse, MD, etc.) | <input type="checkbox"/> Other (specify) _____ |

*At what point in the process was the incident **first discovered**? (check one)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Product check-in | <input type="checkbox"/> Sample receipt | <input type="checkbox"/> Product selection | <input type="checkbox"/> Product administration |
| <input type="checkbox"/> Product/test request | <input type="checkbox"/> Sample testing | <input type="checkbox"/> Product manipulation | <input type="checkbox"/> Post-transfusion review/audit |
| <input type="checkbox"/> Sample collection | <input type="checkbox"/> Product storage | <input type="checkbox"/> Request for pick-up | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Sample handling | <input type="checkbox"/> Available for issue | <input type="checkbox"/> Product issue | _____ |

Occurrence

*Date incident occurred: ___ / ___ / _____

*Time incident occurred: ___ : ___ (HH:MM) Time approximate Time unknown

*Where in the facility did the incident occur? _____

Job function of the worker involved in the incident: (Use NHSN Occupation Codes on page 5.)

___ If Other (OTH), specify _____ Worker unknown

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 10 minutes 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).



*At what point in the process did the incident **first occur?** (check one)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Product check-in | <input type="checkbox"/> Sample receipt | <input type="checkbox"/> Available for issue | <input type="checkbox"/> Request for pick-up |
| <input type="checkbox"/> Product/test request | <input type="checkbox"/> Sample testing | <input type="checkbox"/> Product selection | <input type="checkbox"/> Product issue |
| <input type="checkbox"/> Sample collection | <input type="checkbox"/> Product storage | <input type="checkbox"/> Product manipulation | <input type="checkbox"/> Product administration |
| <input type="checkbox"/> Sample handling | <input type="checkbox"/> Other (specify) _____ | | |

*Incident code: _____ (Use NHSN Incident Codes on page 4.)

Incident summary: (500 characters max)

*Incident result: (check one)

- | | |
|--|--|
| <input type="checkbox"/> 1 – Product transfused, reaction | <input type="checkbox"/> 3 – No product transfused, unplanned recovery |
| <input type="checkbox"/> 2 – Product transfused, no reaction | <input type="checkbox"/> 4 – No product transfused, planned recovery |

*Product action: (check all that apply)

- Not applicable
- Product retrieved
- Product destroyed

^Single or multiple units destroyed?

Single unit:

Code system used: ISBT-128 Codabar

Unit #: _____

OR Component code: _____

Multiple units: (select code system used)

ISBT-128 Codabar Component code: _____ Number of units: _____

ISBT-128 Codabar Component code: _____ Number of units: _____

ISBT-128 Codabar Component code: _____ Number of units: _____

Product issued but not transfused

Product transfused

Was a patient reaction associated with this incident? Yes No

If Yes, Patient ID#(s): _____



*Record/other action: (check all that apply)

- Record corrected Floor/clinic notified Attending physician notified
 Additional testing Patient sample re-collected Other (specify) _____

Investigation Results

*Did this incident receive root cause analysis? Yes No

If Yes, result(s) of analysis: (check all that apply)

- Technical Organizational Human Patient-related
 Other (specify) _____

Custom Fields

Label		Label	
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments

