OMB No. 0920-0666
Exp. Date: xx-xx-xxxx
www.cdc.gov/nhsn

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 Code	*Incident Code	*Total Incidents	*Total Adverse Reactions associated with Incidents
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 and 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 online + 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 arrived without samples + SC 10 Wristband incorrect/not available SC 11 Sample contaminated		
SH: Sample Handling (Service collecting the samples)	SH 00 Detail not specified SH 01 Sample arrived without requisition SH 02 Requisition and sample label don't match + 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		

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

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 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 Code	*Incident Code	*Total Incidents	*Total Adverse

		Reactions associated with Incidents
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 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: 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 audit 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/incorrect checking of product 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 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 Code	*Incident Code	*Total Incidents	*Total Adverse Reactions associated

		with Incidents
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, patient not available RP 05 Product requested for pick-up, IV not ready RP 06 Request for pick-up incomplete RP 10 Product transport issue	
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 Product issue delayed **+** UI 06 LIS warning overridden 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, 2nd check at issue) UI 22 Issue approval not obtained/documented	
UT: Product Administration (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 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	
	Total	

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