Form Approved
OMB No. 0920-xxxx
Exp. Date: XX/XX/20XX
www.cdc.gov/nhsn

Hemovigilance Module - Annual Facility Survey
Non-Acute Care Facility

*Required for saving

*Facility ID#: _____ *Survey Year: _____

For all questions, use information from previous full calendar year.

Facility Characteristics

*1. Ownership: (check one)

☐ Government ☐ Military ☐ Not for profit, including church
☐ For profit ☐ Veteran's Affairs ☐ Physician-owned

*2. Community setting of facility: ☐ Urban ☐ Suburban ☐ Rural

*3. Total number of operating rooms at time of survey completion: _____

*4. Total number of procedure rooms at time of survey completion: _____

*5. Total number of patient admissions in this survey year: _____

*6. Check all the specialty(ies) currently performed in your facility:

☐ Bariatrics ☐ General surgery ☐ Gastroenterology
☐ Gynecology ☐ Neurology ☐ Orthopedic
☐ Plastic surgery ☐ Spine ☐ Urology
☐ Other (specify) _____

Transfusion Service Characteristics

*7. Does your facility provide all of its own transfusion services, including all laboratory functions?

☐ Yes ☐ No, we contract with a blood center for *some* transfusion service functions.
☐ No, we contract with another healthcare facility for *some* transfusion service functions.
☐ No, we contract with another blood center for *all* transfusion service functions.
☐ No, we contract with another healthcare facility for *all* transfusion service functions.

*8. How many dedicated transfusion service staff members are there? (Count full-time equivalents; include supervisors.)

Physicians: ____ Medical Technologists: _____ Medical Laboratory Technicians: _____

*9. Does your facility have a dedicated position or FTE in a quality or patient safety function (e.g., TSO) for investigation of transfusion-related adverse reactions? ☐ Yes ☐ No

*10. Does your facility have a dedicated position or FTE in a quality or patient safety function (e.g., TSO) for investigation of transfusion errors (i.e., incidents)? ☐ Yes ☐ No

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)).

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Transfusion Service Characteristics (continued)

*11. Does your facility have a committee that reviews blood utilization? ☐ Yes ☐ No

*12. Total number of patient samples collected for type and screen or crossmatch: _____

*13. Does your facility perform point-of-issue bacterial testing on platelets prior to transfusion? ☐ Yes ☐ No

Transfusion Service Computerization

*14. Is the transfusion service computerized? ☐ Yes ☐ No (If No, skip to question 17)

If Yes, select system(s) used: (check all that apply) ☐ BBCS® ☐ BloodTrack Tx® (Haemonetics)
☐ Cerner Classic® ☐ Cerner Millennium® ☐ HCLL® ☐ Horizon BB® ☐ Hemocare®
☐ Lifeline® ☐ Meditech® ☐ Misys® ☐ Safetrace Tx® (Haemonetics) ☐ Softbank®
☐ Western Star® ☐ Other (specify) _____

*15. Is the system ISBT-128 compliant? ☐ Yes ☐ No

*16. Does the transfusion service system interface with the patient registration system? ☐ Yes ☐ No

*17. Does your facility use positive patient ID technology for transfusion?

☐ Yes, facility wide ☐ Yes, certain areas ☐ Not used

If Yes, select purpose(s): (check all that apply) ☐ Specimen collection ☐ Product administration

If Yes, select system(s) 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) _____

Transfusion Service Specimen Handling and Testing

*18. Are transfusion service specimens drawn by a dedicated phlebotomy team?

☐ Always ☐ Sometimes, approximately _____% of the time ☐ Never

*19. 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) _____

*20. Are phlebotomy staff members allowed to correct patient identification errors on pre-transfusion specimen labels?

☐ Yes ☐ No

*21. 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) _____