NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

Hemovigilance Module
Incident

***Required for saving**

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

Discovery

*Date of discovery: __ __ /__ __ / __ __ __ __

*Time of discovery: __ __ : __ __(HH:MM) ☐ Time approximate ☐ Time unknown

*Where in the facility was the incident discovered? _____

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

- ☐ Product check-in
- ☐ Order entry
- ☐ Sample testing
- ☐ Satellite storage
- ☐ Product storage
- ☐ Sample collection
- ☐ Product manipulation
- ☐ Product administration
- ☐ Inventory management
- ☐ Sample handling
- ☐ Request for pick-up
- ☐ Post-transfusion review/audit
- ☐ Product/test request
- ☐ Sample receipt
- ☐ Product issue
- ☐ Other _____

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

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

Occurrence

*Date **initial** incident occurred: __ __ /__ __ / __ __ __ __

*Time **initial** incident occurred: __ __ : __ __(HH:MM) ☐ Time approximate ☐ Time unknown

Incident summary: (500 characters max)

_____

_____

_____

_____

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

*Incident code(s): (max 20) *Use NHSN incident codes in the surveillance protocol.*

	Incident Code	Occurrence Location		Incident Code	Occurrence Location
1	__ __ __ __	_____	11	__ __ __ __	_____
2	__ __ __ __	_____	12	__ __ __ __	_____
3	__ __ __ __	_____	13	__ __ __ __	_____
4	__ __ __ __	_____	14	__ __ __ __	_____
5	__ __ __ __	_____	15	__ __ __ __	_____
6	__ __ __ __	_____	16	__ __ __ __	_____
7	__ __ __ __	_____	17	__ __ __ __	_____
8	__ __ __ __	_____	18	__ __ __ __	_____
9	__ __ __ __	_____	19	__ __ __ __	_____
10	__ __ __ __	_____	20	__ __ __ __	_____

☐ MS 99 Miscellaneous, specify _____

Job function of the worker(s) involved in the incident: (max 6) *Use NHSN occupation codes in the protocol.*

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

☐ Other Other (OTH), specify _____ ☐ Worker unknown

*Incident result: (check one)

☐ 1 – Product transfused, reaction
☐ 2 – Product transfused, no reaction
☐ 3 – No product transfused, unplanned recovery
☐ 4 – No product transfused, planned recovery

*Product action: (check all that apply)

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

☐ Not applicable
☐ Product retrieved and returned to inventory
☐ Product retrieved and 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
^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

Custom Fields

Label		Label	
_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments (2000 characters max)

_____

_____

Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn