

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
☐ Product storage	☐ Sample collection	☐ Satellite storage
☐ Inventory management	☐ Sample handling	☐ Product administration
☐ Product/test request	☐ Sample receipt	☐ Request for pick-up
	☐ Product issue	☐ Post-transfusion review/audit
		☐ Other _____
*How was the incident first discovered ? (check one)		
☐ Visual inventory review	☐ Observation by staff of unit/reagent/sample/equipment	
☐ Routine audit or supervisory review	☐ Comparison of product label to patient information	
☐ Computer system alarm or warning	☐ Comparison of product label to physician order	
☐ Comparison of sample to paperwork	☐ When checking patient ID band	
☐ Repeat or sample re-testing	☐ Notification or complaint from floor (nurse, MD, etc.)	
☐ Historical record/previous type check	☐ When product/units returned to lab	
☐ Communication from lab to floor	☐ Patient transfusion reaction	
☐ Human 'lucky catch'	☐ Other (specify) _____	
Occurrence		
*Date initial incident occurred: ____ / ____ / ____		
*Time initial incident occurred: ____ : ____ (HH:MM) ☐ Time approximate ☐ Time unknown		
Incident summary: (500 characters max)		

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)). CDC 57.305, Rev. 7, v9.2

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 H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).

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

*Product action: (check all that apply)

☐ 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)

_____ _____ _____
