

Form Approved OMB No. 0920-0666 Exp. Date: 12/31/22 www.cdc.gov/nhsn

## Hemovigilance Module Incident

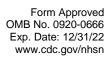
*Required for saving						
*Facility ID#:	NHSN Incident #:	Local Incident # or Log #:				
Discovery						
*Date of discovery: / / _						
*Time of discovery: : : (HI	H:MM)	ne approximate				
*Where in the facility was the incide	nt discovered?					
*At what point in the process was the incident <b>first discovered</b> ? (check one)						
☐ Product check-in ☐ Ord	er entry Sample testing	☐ Satellite storage				
☐ Product storage ☐ San	nple collection	ulation Product administration				
☐ Inventory management ☐ Sample handling ☐ Request for pick-up ☐ Post-transfusion review/audit						
☐ Product/test request ☐ Sam	nple receipt	Other				
*How was the incident <b>first discovered</b> ? (check one)						
☐ Visual inventory review	Observation by sta	aff 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 pape	rwork	atient ID band				
Repeat or sample re-testing	☐ Notification or com	nplaint from floor (nurse, MD, etc.)				
☐ Historical record/previous type check ☐ When product/units returned to lab						
☐ Communication from lab to floo	Patient transfusion	reaction				
Human 'lucky catch'	Other (specify)					
Occurrence						
*Date initial incident occurred: _		_				
*Time <b>initial</b> incident occurred: _	· ,	ne approximate 🔲 Time unknown				
Incident summary: (500 characters	s max)					
Assurance of Confidentiality: The voluntarily prov						
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, a	· <i>,</i>					
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).





	max 20) Use NHSN inci					
Incident Code	Occurrence Location	44	de Occurrence Locat	ion		
1 2		11				
3		12	<del></del>			
4						
5						
6		16				
7						
8		18				
9		19				
10		20				
☐ MS 99 Miscel	laneous, specify					
Job function of the	worker(s) involved in	the incident: (max 6)	Use NHSN occupation codes in the	protocol.		
Other Othe	er (OTH), specify	<del> </del>	Worker unknown			
*Incident result: (c	heck one)					
	ansfused, reaction	3 – No product t	ransfused, unplanned recove	ry		
☐ 2 – Product transfused, no reaction ☐ 4 – No product transfused, planned recovery						
*Product action: (c	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 #:						
	mponent code:					
☐ Multiple units: (select code system used)						
☐ ISBT	-128 Codabar	Component code:	Number of un	its:		
☐ ISBT	-128 Codabar	Component code:	Number of un	its:		
☐ ISBT	☐ ISBT-128 ☐ Codabar Component code: Number of units:					
☐ Product issue	d but not transfused					
☐ Product trans	fused					
^Was a patient reaction associated with this incident?						
^Patient ID#(s	s):					





*Record/other action: (check all that apply)						
Record corrected	☐ Floor/clinic notified		Attending physician notified			
Additional testing	Patient sample re-coll	ected	Other (specify)			
Investigation Results						
*Did this incident receive root cause analysis?						
Custom Fields						
Label		Label				
	/ /					
Comments (2000 char	acters max)					
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