Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
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

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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 identity ☐ Sex at birth
☐ Patient first name ☐ Patient last name ☐ Transfusion specimen ID system (e.g., Typenex®)
☐ Patient verbal confirmation of name or date of birth ☐ Other (specify) _____