

## Hemovigilance Module Annual Facility Survey

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

Data Field	Instructions for Form Completion
Facility ID#	<b>Required.</b> The NHSN-assigned Facility ID number will be auto entered by the NHSN application.
AHA Facility ID#	<b>Required.</b> Enter the AHA-assigned Facility ID number. This ID can be found <a href="#">AHA Guide</a>
Survey Year	<b>Required.</b> Enter the most recent full calendar year. For example, if you complete this survey in January 2026, the survey year will be 2025.
Hemovigilance Module Point of Contact	<b>Required.</b> Enter the name of the person that serves as the point of contact for the facility's Hemovigilance module.
FDA Blood Bank Establishment ID#	Optional. Enter your facility blood bank establishment ID. This ID can be found at FDA BER ID: <a href="#">BLOOD ESTABLISHMENT REGISTRATION - Search Establishment Registration Database - Enter Query</a> .
<b>Facility Characteristics</b> (Note: Section automatically populated from previously saved survey)	
Facility setting	<b>Required.</b> Select the setting that most closely describes the location of your facility. <b>Urban:</b> Areas classified as a Metropolitan Statistical Area by the U.S. Census Bureau; each area must have at least one urbanized area of 50,000 or more inhabitants. <b>Suburban:</b> Areas classified as a Micropolitan Statistical Area by the U.S. Census Bureau; each Micropolitan statistical area must have at least one urban cluster of at least 10,000 but less than 50,000 inhabitants. <b>Rural:</b> Areas classified as Balance of County by the U.S. Census Bureau; there are no urban areas of at least 10,000 inhabitants.
Total number of patient admissions in this survey year:	<b>Required.</b> Record the total number of patient admissions to this facility for the survey year. .
Number of surgeries performed in this survey year:	<b>Required.</b> Enter the total number of inpatient and outpatient surgeries performed at your facility in the past full calendar year. <b>Count inpatient and outpatient areas.</b>
At what trauma level is your facility certified?	<b>Required.</b> Indicate the trauma level (I, II, Other, NA) of your facility.
Do you collect blood for transfusion at your facility?	<b>Required.</b> Check <b>Yes</b> if your facility performs blood collection in-house.
If Yes, check all that apply:	Select allogenic, autologous, or directed blood donation that is collected at your facility.

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Does your facility perform point-of-issue bacterial testing on platelets prior to transfusion?	<b>Required.</b> Indicate 'Yes', 'No', or 'Unknown' if point-of-issue bacterial testing on platelets are performed prior to transfusion at your facility.
Does your healthcare facility provide all of its own transfusion services, including all laboratory functions?	<b>Required.</b> If transfusion services and laboratory support are provided 100% by the facility, check <b>Yes</b> . If <b>No</b> , select the description that most closely represents your facility's transfusion service structure.
How many dedicated transfusion service staff members are there	<b>Required.</b> Indicate, using whole numbers, the number of dedicated transfusion service staff members your facility employs based on job titles and employment type. Enter 0, if none.
Is the transfusion service laboratory accredited?	<b>Required.</b> Select 'Yes' or 'No' if the transfusion service laboratory is accredited.
If Yes, select all accrediting bodies that apply	Check the accrediting organization(s).
<b>Transfusion Computerization</b>	
Does your facility use an electronic blood banking management system	<b>Required.</b> If your facility uses an electronic system for <u>any</u> part of the blood product issuing process, check <b>Yes</b> .
If Yes, select system(s) used	Check all systems that apply.
If Yes, does the system use ISBT-128 codes to record product information?	Indicate whether ISBT-128 is used with this system by selecting 'Yes' or 'No'.
Are transfusions entered into a facility-wide electronic reporting system?	<b>Required.</b> Check <b>Yes</b> if transfusions reported to or occurring within your facility are entered into a system that is used across your facility (as opposed to a system that is maintained entirely within your facility).
If Yes, select system(s) used	Check all systems that apply.
If Yes, does the system use ISBT-128?	Indicate whether ISBT-128 is used with this system by selecting 'Yes' or 'No'.
Are the transfusion-related adverse events (i.e., TACO, TRALI, AHTR, TTI) entered in a facility-wide electronic reporting system?	<b>Required.</b> Check <b>Yes</b> if transfusion-related adverse events reported to or occurring within your facility are entered into a system that is used across your facility (as opposed to a system that is maintained entirely within your facility).
If Yes, select system(s) used	Check all systems that apply.
If Yes, does the system use ISBT-128?	Indicate whether ISBT-128 is used with this system by selecting 'Yes' or 'No'.
<b>Total Units Transfused by Blood Component</b>	
Total number of units transfused at your facility for the survey year	<b>Required.</b> Report the total number of units transfused at your facility for the survey year. Pediatric aliquots should be recorded in standard unit equivalents. For example, if the standard red blood cell unit volume is 500mL and the volume of pediatric aliquots are 50mL (10 pediatric aliquots per standard unit), then record 150 pediatric aliquot

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		transfusions (7,500mL) as 15 units. Data regarding pathogen reduction is optional but would allow CDC to calculate product-specific adverse reaction rates.
	Red Blood Cells	<b>Required.</b> List the number of apheresis, whole blood derived, irradiated, and leukoreduced units transfused and discarded at your facility.
	Apheresis	Optional.
	Whole Blood Derived	Optional.
	Irradiated <sup>1</sup>	Optional.
	Leukoreduced <sup>1</sup>	Optional.
	Platelets	<b>Required.</b> List the number of apheresis, whole blood derived, irradiated, and leukoreduced (only if whole blood derived) units transfused and discarded at your facility.
	Apheresis	Optional.
	Psoralen- treated	Optional.
	Psoralen- treated in plasma	Optional.
	Psoralen- treated in platelet additive solution	Optional.
	Whole Blood Derived <sup>2</sup>	Optional.
	Psoralen- treated	Optional.
	Irradiated <sup>1</sup>	Optional.
	Leukoreduced (only if whole blood derived)	Optional.
	Plasma	<b>Required.</b> List the number of apheresis and whole blood derived units transfused and discarded at your facility.
	Apheresis	Optional.
	Psoralen- treated	Optional.
	Whole Blood Derived	Optional.
	Psoralen- treated	Optional.
	Cryoprecipitated Antihemophilic Factor	<b>Required.</b> List the number of cryoprecipitated fibrinogen complex units transfused and discarded at your facility.  Note: Report the number of individual concentrates pooled into each therapeutic dose. For example, if 6 individual concentrates were pooled to create one cryoprecipitate dose, count 6 units for denominator reporting
	Pathogen Reduction Cryoprecipitated Fibrinogen Complex	Optional. List the number of pathogen reduction cryoprecipitated fibrinogen complex units transfused and discarded at your facility.

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		Note: Report the number of individual concentrates pooled into each therapeutic dose. For example, if 6 individual concentrates were pooled to create one cryoprecipitate dose, count 6 units for denominator reporting
	Whole Blood	<b>Required.</b> List the number of units transfused and discarded at your facility.