Form Approved
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www.cdc.gov/nhsn

Hemovigilance Module
Monthly Reporting Plan

*Required for saving

*Facility ID#: _____ *Month: _____ *Year: _____

All reporting is facility-wide.

☐ Participating in Hemovigilance Module surveillance this month

Participation requires complete reporting of all CDC-defined adverse reactions, reaction-associated incidents, and denominators for the entire month as specified in the surveillance protocol.

- Adverse reactions associated with transfusions
- Incidents (i.e., errors or accidents) associated with adverse reactions
- Denominators (i.e., transfused components and patient samples collected)

☐ Not participating in Hemovigilance Module surveillance this month