# Transplant Administration Survey

1. Provide the name and address of the institution or corporation responsible for the provision of transplant services.

**Legal Name:**

**Name as appears on CIBMTR Center Specific Outcomes Report (if different):**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address:**

**City:**

**State:**  **Zip**:

**Hospital Tax ID Number:**

Chief Executive Officer:

**Program Administrator Telephone: \_\_\_**

|  |  |  |
| --- | --- | --- |
| 2. Is your institution currently licensed by the state’s regulatory agencies?If no, explain: On what date does your State License expire: | Yes [ ]  | No [ ]  |

|  |  |  |
| --- | --- | --- |
| 3. Are there conditions on the current federal, state, or local licenses, permits, or certifications? | Yes [ ]  | No [ ]  |

If yes, explain:

|  |  |  |
| --- | --- | --- |
| 4. Is your institution affiliated with or the parent corporation of other hospitals/institutions? | Yes [ ]  | No [ ]  |

If yes, what is the name(s) of the affiliated institutions and the nature of the relationship?

**5. Are any pre- or post-transplant services**

**(clinic visit, evaluation, major diagnostic testing,** Yes [ ]  No [ ]

**etc.) being provided at the affiliated institutions listed in**

**question 4?**

If yes, please list which affiliate and which type of service.

**6. Is your institution currently accredited by any of the following organizations without exception, condition or contingency?**

|  |  |  |
| --- | --- | --- |
| **Accreditation Organization****(FACT accreditation is addressed in question A-1)** | **YES** | **NO** |
| **The Joint Commission** |  |  |
| **National Integrated Accreditation of Healthcare Organizations (DNV-GL NIAHO)** |  |  |
| **Healthcare Facilities Accreditation Program (HFAP)** |  |  |
| **Center for Improvement in Healthcare Quality (CIHQ)** |  |  |

## 7. Does your institution’s Medical Staff Bylaws contain a comprehensive process for credentialing and re-credentialing of physicians participating in the transplant program (Program), including primary verification of:

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Licensure | [ ]  | [ ]  |
| Previous Appointments | [ ]  | [ ]  |
| DEA Certificates | [ ]  | [ ]  |
| Previous State Medicare / Medicaid Sanctions | [ ]  | [ ]  |
| The National Practitioner Data Bank | [ ]  | [ ]  |

If no for any of the above, please attach a copy of the Bylaws related to physician credentialing and re-credentialing.

## 11. Clinical programs available (mark all that apply):

|  |  |  |
| --- | --- | --- |
| Therapy Type | Adult | Pediatric |
| Allogeneic Matched Related |  |  |
| Allogeneic Haplo Related |  |  |
| Allogeneic Unrelated - PBSC |  |  |
| Allogeneic Unrelated - Marrow |  |  |
| Allogeneic Unrelated - Cord blood |  |  |
| Autologous - Marrow |  |  |
| Autologous - PBSC |  |  |

If services are provided to both adult and pediatric patients, indicate program type:

 [ ]  Separate programs [ ]  Combined program

## 8. Name and address of immunology laboratory affiliated with transplant program:

## 9. Does your institution have the following facilities and services:

| **Special Inpatient and Outpatient Facilities:** | **Yes** | **No** | **# Beds** |
| --- | --- | --- | --- |
| BMT Unit | [ ]  | [ ]  |  |
| Medical Intensive Care Unit | [ ]  | [ ]  |  |
| Surgical Intensive Care Unit | [ ]  | [ ]  |  |
| Pediatric Intensive Care Unit | [ ]  | [ ]  |  |
| Neurological Intensive Care Unit | [ ]  | [ ]  |  |
| General Pediatric Unit | [ ]  | [ ]  |  |
| BMT Clinic | [ ]  | [ ]  |  |
| Home Health Transplant Nursing Specialists | [ ]  | [ ]  |  |
| **Are the following available 24 hours/day, 7 days/week at your institution?** |
| Anesthesiology | [ ]  | [ ]  |
| Pathology | [ ]  | [ ]  |
| Blood banking | [ ]  | [ ]  |
| Renal dialysis | [ ]  | [ ]  |
| Operating rooms | [ ]  | [ ]  |
| Emergency clinical care | [ ]  | [ ]  |

|  |  |  |
| --- | --- | --- |
| 10. Are housing accommodations available for patient(s)/companion(s) during the pre- and post-therapy periods? | Yes [ ]  | No [ ]  |
|  |  |  |

If yes, list and provide information:

## 11. What kind of ongoing training is provided for the transplant staff?

## 12. Key contacts

|  | Administrator or person**completing form** | Contract Manager |
| --- | --- | --- |
| BMT Program |  |  |

I have investigated and certify that the information contained in this survey and all attachments is accurate, complete and true. I understand that submission of this completed survey does not automatically result in continued participation.

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Signature(s) |  |
| Title |  | Date |  |

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