SAMPLE Cover Memo

TO: Heads of all departments and nursing units
FROM: (Name of workgroup)
DATE:
SUBJECT: Survey of device use

The elimination of percutaneous injuries associated with the use of (Type of Device) is a priority of your Sharps Injury Prevention Program Committee. Currently, this type of device accounts for _____% of our sharps injuries each year. One prevention strategy under consideration is the replacement of our conventional (Type of Device) with a device or devices with safety features.

We want to ensure that all areas of the organization that might be affected by the decisions of this committee have input into the decision-making process. Our first step is to conduct an organization-wide survey to identify users of the current device and their unique needs. Please complete the attached survey, and return it to _____ by _____. If you have any questions about the survey or the plans of the committee, you may call _____.

Survey of Device Use

(Example: Hypodermic Needle/Syringe)

Department/Nursing Unit	Person Completing Form	Phone

1. Does your department/nursing unit use hypodermic needles and syringes?

☐ Yes *(Go to next group of questions.)* ☐ No *(Stop here and return this form.)*

2. Does your department/nursing unit obtain this device from the facility's central supply area?

☐ Yes ☐ No *(Complete information on reverse side of this page at bottom.)*

3. For which of the following procedures does your department/nursing unit use this device?

☐ Give injections
☐ Collect blood or other specimen
☐ Access parts of an intravenous system
☐ Withdraw medication
☐ Irrigate

Other: 1. _____ 2. _____ 3. _____

4. Does your department/nursing unit ever use a syringe without an attached needle?

☐ Yes ☐ No

If yes, please list these uses:

1. _____ 2. _____ 3. _____

5. What syringe sizes are used in your department/nursing unit?
(Check all that apply.)

☐ 1 cc Insulin ☐ 1 cc Tuberculin ☐ 3 cc ☐ 5 cc
☐ 10 cc ☐ 20 cc ☐ Other: _____

6. **Is the hypodermic needle/syringe used with other equipment where compatibility might be a concern when considering other devices?**

   ☐ Yes (Please explain.) ☐ No

_____

_____

7. **Does your department/nursing unit need to be able to change needles after drawing medication?**

   ☐ Yes ☐ No

8. **Does your department/nursing unit have any purposes or needs associated with the hypodermic needle/syringe that you consider unique from other hospital areas?**

   ☐ Yes (Please explain.) ☐ No

_____

_____

Comments: _____

_____

_____

_____

Additional information on product supply source: (From question #2)

Name of device manufacturer: _____

Name of supplier: _____

Approximate number of devices stocked: _____