Transfusion Transmission Disease Investigation

Hospital: ________________________ Date Form Completed: ___________ Is Patient Currently Hospitalized? ☐ Yes ☐ No

Patient Name: _________________________________ DOB: ____________ Physician: __________________________

Disease Diagnosed/Date: ____

Period of Tx* From: ____________ To: ____________ Reason for Tx: ____

Other Risk Factors: ____

** List transfused blood products on page 2.*

Date Received at CBC: _______________

CBC Case No.: _______________

Date Case Closed: _______________

Hospital Laboratory Results:

Previous Infectious Disease Testing	Result	Date	Post-Transfusion / Current Serology Tests	Result	Date
HBsAg			HBsAg		
HIV			HIV		
HCV			HCV		
WNV			WNV		

Transfusion Service Medical Director: approval of documentation

Comments: ____

Transfusion Service Medical Director Signature: ____ Date: __________________________

SEND COMPLETED FORM TO CBC BY BLOOD COURIER - ATTN: HOSPITAL SERVICES SUPERVISOR/RECORD REVIEW SPECIALIST

For CBC Use Only:

CBC Medical Director's Conclusion: ☐ Probably Transfusion Related ☐ Probably Not Transfusion Related ☐ Investigation Inconclusive

Comments: ____

Medical Director's Signature: ____________________________________ Date: ____________ Case Findings Mailed By/Date: ________________

For Hospital Use Only[1]			*For CBC Use Only*
Donation # or Manufacturer/Lot #	**Product Code or Product**	**Transfusion Date (MM/DD/YY)**	**Subsequent Donation/Date/Test Result**

[1]*For* ***Hepatitis*** *Cases:* *List products transfused up to 6 months prior to the onset of symptoms.*
For ***HIV*** *Cases:* *List products transfused since 1978.*
For ***WNV*** *Cases:* *List products transfused up to 120 days prior to onset of symptoms.*