

REPORT OF SUSPECTED TRANSFUSION-ACQUIRED INFECTION

To report any suspected transfusion-acquired infection: including hepatitis, HIV, CMV, West Nile Virus

		(Please type or print and con	nplete with as much c	letail as possible)	
(Name of Patier	nt or I.D.)	Date of Birth:	SS#: (optional)		DATE OF REPORT:
PRESENT STATUS OF F	PATIENT: Living Do	eceased If deceased – Date of dea	ath:	Cause of death:	
Hospital:		_ Transfusion Service Physician:		Transfusion Service Super	visor:
CLINICAL PHYSICIAN:	At time of Transfusions	Physician name		Address (Street, City, Zip)	Phone:
	At time of Diagnosis of Infectious Disease:				Phone:
		Physician name		Address (Street, City, Zip)	

TYPE OF INFECTION:

LABORATORY DATA SUPPORTING DIAGNOSIS OF SUSPECTED TRANSFUSION-ACQUIRED INFECTION:

(Please include results of pertinent infectious disease testing, confirmatory testing and other laboratory data supporting diagnosis.)

						POST-TRANSFUSION	
	Yes No	PRE-TRANSFUSION DATE/RESULT	POST-TRANSFUSION DATE/RESULT		Yes No	PRE-TRANSFUSION DATE/RESULT	POST-TRANSFUSION DATE/RESULT
Bilirubin				Anti-HAV (Total)			
AST				Anti-HAV (IGM)			
ALT				Anti-HCV EIA			
Alk Phos				Anti-HCV RIBA			
HBsAg				HCV PCR			
Anti-HBc (Total)				Anti-HIV EIA			
Anti-HBc (IGM)				Anti-HIV WB			
Anti-HBs				HIV PCR			
HBV by PCR				Other			

CLINICAL DATA SUPPORTING DIAGNOSIS OF SUSPECTED TRANSFUSION-ACQUIRED INFECTION:

POSSIBLE RECIPIENT RISK FACTORS (OTHER THAN BLOOD TRANSFUSION):

	Yes	No
Organ/tissue/marrow transplant		
IV drug use		
Sex with IVDU		
Sex with infected partner		
Sex with partner receiving clotting factors		
Close contact with person with hepatitis or HIV		
Male-to-Male sex		

If yes, please explain:_____

Rape Residence/Travel outside US Incarceration, group home Tattoos or piercings Hemophiliac/received clotting factors Needle stick or body fluid exposure	Yes	
Needle stick or body fluid exposure		

	UNIT NUMBER	COMPONENT	TRANSFUSION DATE	UNIT NUMBER	COMPONENT	TRANSFUSION DATE	
	1			7			
	2			8			
	3			9			
	4			10			
	5			11			
	6			12			
	n reviewed by the Medic n reported to the local P						
	ed by:						
iis report prepare	ed by	Name and Title			r none.		
		LifeStream	nce				
			CA 92402-1429			ossible sources of infection. Is disease testing.	A summary
		P.O. Box 1429 San Bernardino, (g documentation to 90	CA 92402-1429)9-386-6817 . Thank you.	if donors need to be ca			A summary
port will be sent		P.O. Box 1429 San Bernardino, (g documentation to 90 ation is complete. This	CA 92402-1429 9 9-386-6817 . Thank you. 5 may take several months	if donors need to be ca	lled back for infectiou		
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