# RESPONSE FROM PHYSICIAN TO TRANSFUSION SERVICE

## (HIV, HCV)LOOKBACK RECIPIENT STATUS

**Lookback Case ID:**_____

**Unit Number:**_____ **ABO/Rh:**_____ **Component:**_____

**RECIPIENT STATUS**

_____ _____
Patient Name/Medical Record Number (optional) Date of Birth

Current Status: ☐ Alive ☐ Deceased Date of Death:_____
☐ Unknown ☐ Other (Please explain)_____

Recipient Testing Status:

Was the recipient tested for (Fill In) prior to transfusion? ☐ Yes ☐ No

Has the recipient been tested for (Fill In) subsequent to the transfusion? ☐ Yes ☐ No
If "yes" please indicate test results:_____
Date of testing:_____

Please list any clinical data indicating evidence of transfusion associated infectious disease:

_____

_____

Please indicate any possible recipient risk factors other than blood:

_____

_____

**FORM SUBMITTED BY:**

Name:_____ Title:_____
*(Please Print)*

Signature:_____ Date:_____

**Return the original to** **«TSD»**
**HOSPITAL TRANSFUSION SERVICE DIRECTOR**

**«Hospital_Name»**
**HOSPITAL**

**Regulatory agencies require that blood centers and transfusing facilities conduct lookback investigations in a very timely manner. Please make every effort to return this form within a maximum of 4 weeks from the receipt of the lookback packet.**

**If you have further questions regarding HIV, HCV lookback or recipient notification contact the Medical Surveillance Department at LifeStream (909) 885-6503 extension 655.**