LifeStream
GIVE HOPE | GIVE LIFE | GIVE BLOOD

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 complete with as much detail as possible)

_____ Date of Birth:_____ SS#:_____ ☐Male ☐Female DATE OF REPORT:_____
(Name of Patient or I.D.) (optional)

PRESENT STATUS OF PATIENT: ☐Living ☐Deceased If deceased – Date of death:_____ Cause of death:_____

Hospital:_____ Transfusion Service Physician:_____ Transfusion Service Supervisor:_____

CLINICAL PHYSICIAN: At time of Transfusions:_____ _____ Phone:_____
Physician name Address (Street, City, Zip)

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.)

	Yes	No	PRE-TRANSFUSION DATE/RESULT	POST-TRANSFUSION DATE/RESULT	POST-TRANSFUSION			
						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		Yes	No
Organ/tissue/marrow transplant	☐	☐	Rape	☐	☐
IV drug use	☐	☐	Residence/Travel outside US	☐	☐
Sex with IVDU	☐	☐	Incarceration, group home	☐	☐
Sex with infected partner	☐	☐	Tattoos or piercings	☐	☐
Sex with partner receiving clotting factors	☐	☐	Hemophiliac/received clotting factors	☐	☐
Close contact with person with hepatitis or HIV	☐	☐	Needle stick or body fluid exposure	☐	☐
Male-to-Male sex	☐	☐			

If yes, please explain:_____

_____

LIST EACH KNOWN BLOOD COMPONENT ADMINISTERED PRIOR TO FIRST EVIDENCE OF INFECTION.

(If necessary, provide list on additional paper.)

UNIT NUMBER	COMPONENT	TRANSFUSION DATE	UNIT NUMBER	COMPONENT	TRANSFUSION DATE
1			7		
2			8		
3			9		
4			10		
5			11		
6			12		

Has this case been reviewed by the Medical Director of the blood bank? ☐YES ☐NO Conclusion/Interpretation: _____

Has this case been reported to the local Public Health Department? ☐YES ☐NO Date reported: _____

This report prepared by: _____ Phone: _____
Name and Title

Please mail completed report to: Medical Surveillance
LifeStream
P.O. Box 1429
San Bernardino, CA 92402-1429

You may also fax report and supporting documentation to 909-386-6817. Thank you. The involved donors will be investigated as possible sources of infection. A summary report will be sent to you once the investigation is complete. This may take several months if donors need to be called back for infectious disease testing.

FOR BLOOD CENTER USE ONLY

Date Report Received: _____ Complete: ☐ YES ☐ NO Total number of components: _____ Case ID: _____

Additional Data Requested From: _____ Date Requested: _____ Date Received: _____

Date Donor Checklists initiated: _____ Date Outside Blood Supplier Notified: _____ Public Health Inquiry: ☐YES ☐NO

MEDICAL DIRECTOR'S INITIAL REVIEW AND COMMENTS:

_____
Medical Director Date

QA REVIEW: _____ _____
Name Date