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.