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.*