

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		

For Hospital Use Only:

Transfusion Service Director's Conclusion: Probably Transfusion Related Not Transfusion Related

Comments: _____

Transfusion Service Director's Signature: _____ Date: _____

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: _____

