

## 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: \_\_\_\_\_

## Transfusion Transmission Disease Investigation

<i>For Hospital Use Only<sup>1</sup></i>			<i>For CBC Use Only</i>	
Donation # or Manufacturer/Lot #	Product Code or Product	Transfusion Date (MM/DD/YY)	Verified Current Donation Tested Negative (√)	Subsequent Donation/Date/Test Result

<sup>1</sup>*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.*