Suspected Transfusion Transmitted Infection Report

Innovative Blood Resources

IBR Case # _____

Name of Institution Reporting: _____ Date _____

Name of Individual Completing Form: _____

Recipient's Name _____ Date of Birth _____

Recipient's Medical Record or Social Security number _____

Primary Diagnosis at time of transfusion _____

Hospital where recipient transfused _____

Suspected Transfusion Associated Infection _____

Status: ☐ Recovered ☐ Convalescing ☐ Acute Illness ☐ Deceased

Date range of transfusion _____ Date of onset of clinical symptoms _____

Clinical history _____

_____

_____

Recipient Testing Results:

Date	HBsAg	NAT HBV	anti-HBc	anti-HCV primary	anti-HCV secondary	NAT HCV	anti-HIV-1/2	NAT HIV	HIV Western Blot/IFA	anti-HIV-2

Recipient Liver Function Test Results:

Date	ALT	AST	Bilirubin	Other

Other laboratory or clinical data supporting transfusion transmission? _____

_____

_____

Any other possible recipient risk factors other than transfusion? (Describe) _____

_____

_____

_____

Suspected Transfusion Transmitted Infection Report

Suspected Transfusion Transmitted Infection Report (cont.)

Components Transfused

Date	Unit Number	Component	Date	Unit Number	Component

Please use a separate sheet if more than 30 components

Has recipient received any other blood products such as albumin or coagulation factor concentrates? (Please list)_____

_____

IBR Case # _____

Mail to: **Select IBR Division**

☐ **Memorial Blood Centers**
Physician Services
737 Pelham Blvd.
St. Paul, MN 55114-1739
651-332-7287
FAX 651-332-7001

☐ **Nebraska Community Blood Bank**
Physician Services
100 N 84 St
Lincoln, NE 68505
402-486-9419
FAX 402-486-9429