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 ____

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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? ___________________________

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

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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)____

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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