

Transfusion Transmitted Infection Report

Use this form to report possible transfusion-transmitted infections including viral, parasitic, and prion infections.

Reporting Hospital:	Date:
Individual Reporting:	Contact Phone #:
Blood Bank Medical Director:	Contact Phone #:
Recipient's Physician:	Contact Phone #:

Recipient Name:	DOB:
Hospital ID #:	
Underlying illness or surgery:	
Symptoms of infection or asymptomatic:	

For Human Immunodeficiency Virus (HIV)

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
Anti-HIV		
Western Blot		
Nucleic Acid Test (NAT)/PCR		

Note: Either Western Blot or NAT/PCR must be positive prior to SDBB investigation.

For Hepatitis A Virus (HAV) or Parvovirus B19

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
IgM antibody to:		
Other test information		

Note: IgM antibody post-transfusion or other tests demonstrating recent or active infection must be positive prior to SDBB investigation.

For Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV) or other hepatitis

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
HB surface Antigen (HBsAg)		
Anti-HBcore		
Anti-HBsurface		
HBV nucleic acid test (NAT)		
SGOT (AST)		
SGPT (ALT)		
Bilirubin		
Anti-HCV		
HCV RIBA		
PCR		
Other test information:		

Note: anti-HCV must be confirmed with positive RIBA or PCR prior to SDBB investigation.

Known Risk Factors (Check Yes or No)

Exposure to Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No IV drug use <input type="checkbox"/> Yes <input type="checkbox"/> No Hemodialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation: _____ High risk sexual activities <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____
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For possible West Nile Virus (WNV)

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
Anti-WNV IgM (site) _____		
Anti-WNV IgG (site) _____		
Nucleic Acid Test (NAT) ____		

Note: Either NAT or IgM must be positive prior to SDBB investigation.

For other possible transfusion transmitted infections

Test	Pretransfusion Result/Date	Post-transfusion Result/Date

List all involved units of blood, blood component, or blood derivative administered to the patient (include products from all sources).

	Source	Type of Product	Whole Blood Number/Lot #	Transfusion Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Attach additional forms if more than 10 products transfused.

Has this case been reviewed by Hospital Transfusion Committee? Yes No

If Yes, Transfusion Committee conclusions:

Additional Comments (such as additional history, test results, risk factors, medications or travel):

Mail or fax to: Medical Director, San Diego Blood Bank
3636 Gateway Center Ave, Suite 100, San Diego, CA 92102
Fax # 619-220-8416