Hoxworth Blood Center 3130 Highland Avenue Cincinnati, OH 45267-0055	**Completed**	
	Document #:	**QAD-508-FORM**
	Effective Date:	Nov 29, 2016
	Revision:	3
	Transfusion Transmitted Disease Investigation Report	

(Hoxworth Blood Center is required to investigate all such cases under Code of Federal Regulations 21, 606.170 (a))

Recipient Information:

PATIENT NAME &/or CASE ID:_____ D.O.B. _____ Sex: Female □ Male □

(Hospital identification number)

PRIMARY DIAGNOSIS _____

Current Status: □ Living □ Deceased: If deceased, date and cause: _____

DISEASE THAT MAY HAVE BEEN TRANSFUSION ACQUIRED □ HBV □ HCV □ HIV □ HTLV □ Syphilis
□ West Nile Virus* □ Chagas □ Zika □ Other: _____

Patient's Attending Physician:	Consignee / Hospital Name:
Address:	Address:
Phone #	Phone #

Form completed by:_____ Date: _____ Phone: _____

Attach recipient transfusion history or list the unit numbers, dates transfused and product code or type of component. If more than 10 units were transfused, use additional forms or attach a computer printout.

Unit Number	Date transfused	Product Code or Component	Unit Number	Date transfused	Product Code or Component

***WNV Cases: List products transfused up to 120 days prior to onset of symptoms.**

RETURN COMPLETED FORM (Page 1 & 2) TO HOXWORTH BLOOD CENTER WITH ATTENTION TO: Laurel Wysocki, RN
Manager, Donor Quality Assurance
Telephone: (513) 558-1317 FAX: (513) 558-1395

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PATIENT NAME &/or CASE ID: _____

List clinical data supporting a diagnosis of post transfusion infectious disease and possible recipient risk factors, other than blood transfusion.

_____

If you suspect blood products were transfused at another institution, identify that institution: _____

Laboratory Findings

Was the recipient tested prior to transfusion? _____ List pre and post transfusion test results in the table below. Record Initial Screening (**EIA)** and **CONFIRMATORY** as **NEG** (negative), **POS** (positive) or **IND** (indeterminate). Confirmatory results must be recorded for the investigation to proceed.

HEPATITIS

	Test Date	HBsAG EIA / Conf.		anti-HBs Initial / Conf.		anti-HBc total / IgM		anti-HCV EIA / Conf.		SGOT / SGPT	Other
Pre-trans											
Post-trans											

HIV

	Test Date	anti-HIV		HIV BY PCR OR COMPARABLE TEST	OTHER HIV TESTS, SPECIFY
		EIA	WESTERN BLOT		
Pre-trans					
Post-trans					

OTHER INFECTIONS

	Test Date	anti-HTLV	STS VDRL / FTA	WNV	Chagas (*Trypanosoma cruzi*)	Zika	OTHER
Pre-trans							
Post-trans							