

Hoxworth Blood Center  
 3130 Highland Avenue  
 Cincinnati, OH 45267-0055

<b>Completed</b>	
<b>Document #:</b>	<b>QAD-508-FORM</b>
<b>Effective Date:</b>	Nov 9, 2012
<b>Revision:</b>	2
<b>Transfusion Transmitted Disease Investigation Report</b>	

(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  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

Hoxworth Blood Center  
 3130 Highland Avenue  
 Cincinnati, OH 45267-0055

Completed

Document #: QAD-508-FORM

Effective Date: Nov 9, 2012

Revision: 2

Transfusion Transmitted Disease Investigation Report

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		anti-HBs		anti-HBc		anti-HCV		SGOT / SGPT	Other
		EIA	/ Conf.	Initial	/ Conf.	total	/ IgM	EIA	/ Conf.		
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 ( <i>Trypanosoma cruzi</i> )	OTHER
Pre-trans						
Post-trans						