

LifeShare Blood Center

Suspected Transfusion-Transmitted Infection

To be completed by nurse or physician

WHEN A TRANSFUSION-TRANSMITTED INFECTION IS SUSPECTED:

Complete this form and submit to LifeShare Blood Center

Medical Director at:

LifeShare Blood Center	or Fax to:
8910 Linwood Avenue	
Shreveport, LA 71106-6508	(318) 424-2126
ATTN: Medical Director	ATTN: Medical Director

Patient ID number: _____

Doctor: _____

Facility name: _____

Facility location: _____

PATIENT HISTORY

1. Current diagnosis: _____
2. Date of admission: _____
3. Previous transfusion: Yes No Information unavailable

TRANSFUSION HISTORY *(use back of form, if necessary)*

Unit Number	Component	Date Transfused

LABORATORY DATA *(use blank spaces for tests not listed)*

Test	Pre-Transfusion		Post-Transfusion	
	Date	Result	Date	Result
HBsAg				
HBs confirmation				
Anti-HBs				
Anti-HBc				
HBV DNA				
Anti-HCV				
HCV supplemental				
HCV RNA				
HIV EIA				
HIV confirmation				
HIV RNA				

NT – not tested

Information provided by: _____ Date: _____

Interpretation of test results: _____

Interpretation completed by: _____ MD Date: _____