

CBC Use Only
PTD# _____
Date Rec'd _____
Date Closed _____

Report of Suspected Post Transfusion Disease (PTD)

Recipient Information:

Patient Name: _____ DOB: _____ Sex: Female Male

Diagnosis at time of transfusion: _____ Attending Physician: _____

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

Disease that may have been transfusion acquired: HBV HCV HIV West Nile Virus Other: _____

Laboratory Findings: Was the recipient tested prior to transfusion? Yes No

List pre and post transfusion test results in the table below. **Confirmatory results must be recorded for the investigation to proceed.**

Hepatitis	Test Date	HBsAg		Anti-HBs		Anti-HBc		Anti-HCV EIA	HBV PCR	HCV PCR
		EIA	Conf	Initial	Conf	Total	IgM			
Pre-Trans										
Post-Trans										

HIV	Test Date	Anti - HIV		HIV PCR	Other HIV tests, specify
		EIA	Western Blot		
Pre-Trans					
Post-Trans					

Other Infections	Test Date	WNV	Other tests, specify
Post-Trans			

Transfusion Facility: _____

Date Disease Suspected: _____

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

Transfused with units from CBC? Yes No

Transfused with units from other facility? Yes No # of units: _____

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.**

Has patient been assessed for risks of exposure (e.g., IV drug use, tattoos, acupuncture, ear piercing, sexual contact with infected partner, etc)?

Could the event be related to causes other than transfusion. (Dialysis, receipt of clotting factors in the past, occupational exposure to blood or body fluids (needle stick, spill, bite, etc))? _____

Additional comments: _____

Form completed by: _____ Date: _____ Phone: _____

Blood Bank Director: _____ Signature of Blood Bank Director: _____ Date: _____

Fax signed and completed form to 816-277-0707 Attn: Notification Support Specialist, Community Blood Center

CBC USE ONLY: Investigate as PTD? Yes No

Defer donors without downstream donations? Yes No

Medical Director Review: _____

Date: _____