Report of Suspected Transfusion Transmitted Infection

Transfusing Facility ________________ **Date Reported** ___________ **Patient Name/ID** _____________________ **Form Completed By** ________________

Suspected Transmitted Infection ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ HTLV ☐ Syphilis ☐ Chagas ☐ West Nile Virus ☐ Other ______________________

Unit #	Product Code	Date Transfused	Donor ID (Internal Use Only)	Donation Date (Internal Use Only)	Unit #	Product Code	Date Transfused	Donor ID (Internal Use Only)	Donation Date (Internal Use Only)

Return completed form to LifeServe Blood Center - Email: QARA@lifeservebloodcenter.org or Fax: (515) 883-3268

Subsequent Donation/Test Sample Information (Completed by LifeServe Blood Center) **Date Received at LifeServe:** __________________

Test Results: NR=Non-Reactive R = Reactive NEG=Negative IND=Indeterminate (Complete section of testing for suspected TTI only)

Donor ID	Unit Number	Donation Date	Anti-HIV 1/2	HIV NAT	HBsAg	Anti-HBc	HBV NAT	Anti-HCV	HCV NAT	Anti-HTLV	WNV NAT	Syphilis	Chagas	Other:

Does donor(s) need additional testing? ☐ Yes ☐ No Donor ID __________ Date of 1st notification:________ 2nd notification:________ 3rd notification:________

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