Transfusing Facility _____ **Date Reported** _____ **Patient Name/ID** _____ **Form Completed By** _____

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

Unit #	Date Transfused	Unit #	Date Transfused	Unit #	Date Transfused

Return completed form to LifeServe Blood Center **Email: Qualityandtraining@lifeservebloodcenter.org** **or Fax to 515-883-3268**

Date Received at LifeServe _____

To be completed by Lifeserve Blood Center: **Test Results NR=Non Reactive R = Reactive P=Positive N=Negative I=Indeterminate**

Date of Donation	Donor ID	Date of testing after implicated donation or return testing	Anti-HIV 1/2	HIV NAT	HBsAg	Anti-HBc	HBV NAT	Anti-HCV	HCV NAT	Anti-HTLV	WNV NAT	Zika NAT	Syphilis	Other

Does donor(s) need additional testing? ☐ Yes ☐ No Donor ID _____ Date of 1st notification_____ Date of 2nd notification_____

Donor ID _____ Date of 1st notification _____ Date of 2nd notification _____

Quality Review _____ Date _____