Use this form to report possible transfusion-transmitted infections including viral, parasitic, and prion infections.

Reporting Hospital:	Date:
Individual Reporting:	Contact Phone #:
Blood Bank Medical Director:	Contact Phone #:
Recipient's Physician:	Contact Phone #:

Recipient Name:	DOB:
Hospital ID #:	
Underlying illness or surgery:	
Symptoms of infection or asymptomatic:	

For Human Immunodeficiency Virus (HIV)

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
Anti-HIV		
Western Blot		
Nucleic Acid Test (NAT)/PCR		

Note: Either Western Blot or NAT/PCR must be positive prior to SDBB investigation.

For Hepatitis A Virus (HAV) or Parvovirus B19

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
IgM antibody to:		
Other test information		

Note: IgM antibody post-transfusion or other tests demonstrating recent or active infection must be positive prior to SDBB investigation.

For Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV) or other hepatitis

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
HB surface Antigen (HBsAg)		
Anti-HBcore		
Anti-HBsurface		
HBV nucleic acid test (NAT)		
SGOT (AST)		
SGPT (ALT)		
Bilirubin		
Anti-HCV		
HCV RIBA		
PCR		
Other test information:		

Note: anti-HCV must be confirmed with positive RIBA or PCR prior to SDBB investigation.

Known Risk Factors (Check Yes or No)

Exposure to Hepatitis ☐ Yes ☐ No
IV drug use ☐ Yes ☐ No
Hemodialysis ☐ Yes ☐ No

Occupation: _____
High risk sexual activities ☐ Yes ☐ No
Other: _____

For possible West Nile Virus (WNV)

Test	Pretransfusion Result/Date	Post-transfusion Result/Date
Anti-WNV IgM (site) _____		
Anti-WNV IgG (site) _____		
Nucleic Acid Test (NAT) ___		

Note: Either NAT or IgM must be positive prior to SDBB investigation.

For other possible transfusion transmitted infections

Test	Pretransfusion Result/Date	Post-transfusion Result/Date

List all involved units of blood, blood component, or blood derivative administered to the patient (include products from all sources).

	Source	Type of Product	Whole Blood Number/Lot #	Transfusion Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Attach additional forms if more than 10 products transfused.

Has this case been reviewed by Hospital Transfusion Committee? ☐ Yes ☐ No
If Yes, Transfusion Committee conclusions:

Additional Comments (such as additional history, test results, risk factors, medications or travel):

Mail or fax to: Medical Director, San Diego Blood Bank
3636 Gateway Center Ave, Suite 100, San Diego, CA 92102
Fax # 619-220-8416